ASSESSING THE IMPACT OF THE RESPONSE TO GENDER BASED VIOLENCE (GBV) INTERVENTIONS IN GWEMBE DISTRICT.

BY

MORRIS DEBSON MALAMBO

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE AT THE UNIVERSITY OF ZAMBIA

THE UNIVERSITY OF ZAMBIA

LUSAKA

2023

COPY RIGHT

DECLARATION

I, **Morris Debson Malambo**, hereby declare that this Dissertation entitled "Assessing the Impact of the Response to Gender Based Violence (GBV) Intervention in Gwembe District" is original and an outcome of my own effort. Its contents have never been submitted before for any degree or examination either wholly or partially at this or any other University.

…… ……

Signature Date

APPROVAL

This Dissertation submitted by Morris Debson Malambo is approved as fulfilling part of the requirements for the award of the degree of Master of Science of Public Health by the University of Zambia.

Supervisor

Name: ……

Signature: …….Date:……..……

Coordinator

Name: ……

Signature: …….Date:……...……

ABSTRACT

Background: Records at the Victim Support Unit (VSU) of the Zambia Police Service show that reported GBV cases annually from 2012 indicate an upward increase from 12,924 cases in 2012 to 18,080 in 2015, and 22,073 cases in 2018, to 25,121 cases in 2019, while in 2020 cases shot to 26,370 before showing a slight drop to 20,540 in 2021. (www.zambiapolice.gov.zm).

Main objective: To assess the effectiveness of the response to Gender based violence interventions against women and girls in Gwembe district.

Method: A quantitative cross sectional survey that was "Assessing the impact of the response to Gender Based Violence (GBV) intervention in Gwembe District-Zambia'' The study was a descriptive cross-sectional in nature where a multistage random sampling procedure was used to select 8 wards and 16 villages. A systematic sampling was used to determine household interval in each village. A total of 102 respondents had either experienced or survived GBV in Gwembe district plus 17 key informants (implementers/stakeholders) comprised the sample under study. The study used semi-structured questionnaires to collect primary data. The study report is presented using descriptive statistics namely, frequencies and percentages.

The findings were as follows: women realization of corporal punishment as being abuse stood at 89.9%, while whether GBV cases had declined in Gwembe district declined was 76.5%. However, reporting of cases of abuse to VSU stood at only 9.8%.

With regard to impact of the response interventions against GBV in Gwembe district, efforts to bring the perpetrators to book by VSU was (10) 100% of 10 survivors, however the (92) 90.2% of 102 survivors did not report their abuse to VSU but handled the abuse domestically, usually by survivors' relatives who charged the perpetrator with an animal e.g cow or some goats. The study found a significant relationship between distance and reporting of abuse to VSU as the majority of women (72) 70.6% of 102 women who survived GBV lived within 5km radius, while survivors that lived beyond 15 km accounted for (22) 21.6 %, thus distance was a hindrance to reporting of cases.

The study recommends that Government and cooperating:

i. Establish a GBV response centre within Gwembe valley.
ii. To consider establishing a GBV one stop centre in Gwembe.

DEDICATION

To my loving and ever caring wife Winnie Ngongolo, my lovely children; Leyson, Ittai Thandeka, Samuel David & Malele Monica, my mother Ms. Philis Hanswi plus the entire family. Further, I dedicate this dissertation to my aunt Miss Monica Habanyama who sponsored me to high school and college.

They gave me the encouraging words and support throughout the period I was doing this study though they were denied of my love and care during my busy days.

ACKNOWLEDGEMENTS

I am indebted to the commitment and profound support from my supervisors Dr. Cosmas Zyambo and Mr. Chrispin Chomba for their insight, guidance and wisdom that kept this work focused and plausible. This was not an easy task, as it demanded full commitment, dedication and selflessness towards the task of providing me with vital information that assisted in the refining process of the document.

I am also grateful to Mr. and Mrs. Edwin Hamilube of Gwembe District for not only their hospitality but also assistance in the process of data collection. I am also indebted to acknowledge Mr. Michelo Simwiile for his tireless input mostly during data entry, analysis and presentation phases. He was very instrumental.

My profound gratitude goes to all key government departments at Gwembe District for their support during data collection. Further, I may fail in my duties if I do not extend my special thanks to my family and all my friends, colleagues and associates that were an inspiration to me.

Above all I am grateful to my Lord Jesus Christ for the strength and good health He gave me during my period of study.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

CEDAW: Convention on the Elimination of all Forms of Discrimination against Women of 1979

FISO: Foundation for Intact Society

GBV: Gender Based Violence

GFP: Gender Focal Point

GBVSS: Gender-based Violence Survivor Support

ILO: International Labor Organization

KII: Key informant interview

NAP-GBV: National Action Plan on Gender-Based Violence

ODI: Oversees Development Institute

OSC: One Stop Centre

VSU: Victim Support Unit

SGBV: Sexual and Gender Based Violence

UN: United Nations

UNDP: United Nations Development Programme

UNHCR: United Nations High Commissioner for Refugees

WVZ: World Vision Zambia

YWCA: Young Women's Christian Association

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This study aimed at Assessing the Impact of the Response to Gender Based Violence (GBV) Intervention in Gwembe District. It is quantitative research and cross sectional survey in nature. A multistage random sampling procedure was used to select villages and a systematic sampling was utilized to arrive at participant's households to obtain a total of 102 participants. This study was guided by the following objectives: 1) to determine whether there is involvement of key local stakeholders in response interventions against GBV in Gwembe district by partners/stakeholders. 2) To assess the relevance of the response interventions against gender-based violence against women and girls in Gwembe District. 3) To identify enabling factors for an effective GBV response intervention in Gwembe District. 4) To examine whether existing GBV programs are responsive to the needs of survivors of GBV in Gwembe District. Furthermore, the information was collected using the interview guide and the focus group discussion. After that data was analyzed using Statistical Software package.

This chapter presents the background of the study, statement of the problem, purpose of the study, specific objectives, research question, significance of the study, delimitation of the study, limitation of the study, conceptual framework, definitions of key terms and ethical considerations.

1.2 Background of the Study

Records at the Victim Support Unit (VSU) of the Zambia Police Service show that reported GBV cases annually from 2012 indicate an upward increase from 12,924 cases in 2012 to 18,080 in 2015, and 22,073 cases in 2018, to 25,121 cases in 2019, while in 2020 cases shot to 26,370 before showing a slight drop to 20,540 in 2021. (www.zambiapolice.gov.zm). However, the picture remains relatively worrying country wide. Violence against women remains one of the most pervasive, global health, human rights, and development issue that transcend geography, class, culture, age, race and religion to touch every community in every corner of the globe. It has been estimated that at least one in every three women around the world has been beaten, coerced in to sex, or otherwise abused in her lifetime. (https://www.unfpa.org/gender-based-violence). The

public health implications of this violence are enormous: according to a world development report, violence is more serious a cause of death and incapacity among women of reproductive age as cancer, and greater cause of ill-health than traffic accidents and malaria combined. It drains a country‘s resources and handicaps women‘s ability to contribute to social and economic progress. Hence, society as a whole is affected and it has a major public health consequences.

Yet, in spite of the overwhelmingly negative impact of violence against women on individuals and societies, it is often sanctified by customs and reinforced by institutions that limit women‘s rights, their decision-making power, and their recourse to protection from violence. As such, violence against women is both an outcome and an expression of women‘s subordinate status in relation to men in societies around the world.

The United Nations Declaration on the Elimination of Violence against Women has defined violence against women as ―any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life. (https://www.unfpa.org/gender-based-violence) The UN Declaration makes the link between gender-based oppression and violence against women clear in emphasizing that violence against women is a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women.

It is also worth noting that wherever women are oppressed by their gender roles, children may be at increased risk of violence.

Despite a number of interventions aimed at halting the vice, through multi-sectoral efforts with the support of cooperating partners, for example, The Joint Programme on Gender Based Violence a four-year multi-sectoral programme (July 2012-December 2016) designed to respond to the Gender Based Violence (GBV) context in Zambia, which is characterized by a high prevalence of GBV cases. The programme sought to respond to the GBV context through supporting the Government of the Republic of Zambia (GRZ) to implement the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), with particular focus on the recommendations on violence against women that are contained in the July 2011 CEDAW concluding observations and the recommendations of the Special Rapporteur on Violence against

women, its causes and consequences. The programme, which had a planned budget of USD $15,570,000, was funded by the embassies of Sweden and Republic of Ireland, with core resource contributions from UNDP, UNICEF, UNFPA, UNHCR and ILO. The programme had a specific goal of reducing cases of Gender Based Violence (GBV) in Zambia. The overall objective of the programme was to establish an integrated and multi-sectoral mechanism for the implementation of the Anti-Gender Based Violence Act. The programme was anchored on four outcome areas of Health, Justice, Social Protection and Economic Empowerment and Coordination. A coordinated, multi-sectoral approach was used to implement the programme and this brought together seven UN agencies and more than 25 government and non-state actors led by the Ministry of Gender. George Zimbiri et.al (2017).

1.3. Statement of the Problem

Gwembe district of Southern province faces a number of challenges, apart from lacking industries or commerce to provide job opportunities for the majority of the indigenous citizens, the larger part of the district is a valley that is perpetually affected by droughts, according to CERF/UNFPA (2019). These factors among others increase the risk of protection concerns, especially violence against women and girls, particularly for the most vulnerable women and girls (Cerf.un.org (>19-PR-ZMB-39661). Records obtained from the VSU at Gwembe police station shows that in 2020 a total of 150 GBV cases were recorded against women of childbearing age and girls. Among the forms of sexual abuses recorded, defilement and early marriages were some of them. In order to curb the negative vise, the government of the republic of Zambia in conjunction with its supporting partners; such as UNFPA, YWCA, World Vision, heifer among others have been funding humanitarian response interventions in Gwembe district, aimed at ending Gender Based Violence in all its forms. The most recent funding was by CERF through UNFPA, implemented by YWCA in partnership with ministry of community development-coordinated by a local consultant hired by UNFPA. Despite all the above interventions, statistics show that cases of Gender-Based Violence in Gwembe district have continued escalating. Reason for the escalation of the vise in light of all the interventions and measures put in place remain unknown.

1.4. The Purpose of Study

Issues of Gender base Violence have vast validity. A study like this one will provide stakeholders and relevant decision makers to find ways of increasing sufficient collaboration in designing and implementation of high impact interventions in the response against gender based violence in Gwembe district. Further, the findings of this study may assist government technocrats involved in national planning and development, including Un-Agencies like UNFPA, UNDP, relevant CSOs like; YWCA, HEIFER, FISO, Men against Gender-Based violence network, to understand a cost-effective way of managing the escalating cases of GBV in Gwembe and similar districts, and ultimately bring the vise under control.

1.5. Research Objectives

1.5.1 General Objectives

To assess the effectiveness of the response to Gender based violence interventions against women and girls in Gwembe district.

1.5.2 Specific Objectives

i. To determine whether there is involvement of key local stakeholders in response interventions against GBV in Gwembe district by partners/stakeholders.

ii. To assess the relevance of the response interventions against gender-based violence against women and girls in Gwembe District.

iii. To identify enabling factors for an effective GBV response intervention in Gwembe District.

iv. To examine whether existing GBV programs are responsive to the needs of survivors of GBV in Gwembe District.

v. To draw key lessons for designing and implementing of GBV response interventions targeting a district of similar settings.

1.6 Research Questions

i. How effective is the response to Gender-Based Violence intervention in Gwembe district?

ii. How does the community rate the relevance of the interventions implemented by the government and partners against gender-based violence against women and girls?

iii. What are the enabling factors for an effective and responsive GBV response interventions

iv. Are existing GBV programs responsive to the needs of survivors of GBV in Gwembe District?

1.7 Significance of the Study

Following the review of literature on studies conducted in Gwembe District on this matter, there is scarcity of data on studies investigating the effectiveness of the response to GBV interventions in Gwembe district. Thus the findings of this study will provide evidence-based information on the effectiveness of the response to sexual and gender-based violence interventions in Gwembe district and will help the relevant government wings i.e., The Ministry of Community Development and Social Welfare, The Ministry of Home Affairs and Internal Security, The Ministry of Health, Policy makers, Un-Agencies like UNFPA, UNDP, other relevant stakeholders and CSOs; YWCA, HEIFER, Men against Gender-Based violence network and the evidence generated from this study will help to strengthen programme designing and implementation of similar approaches in assessing the effectiveness of response interventions to GBV.

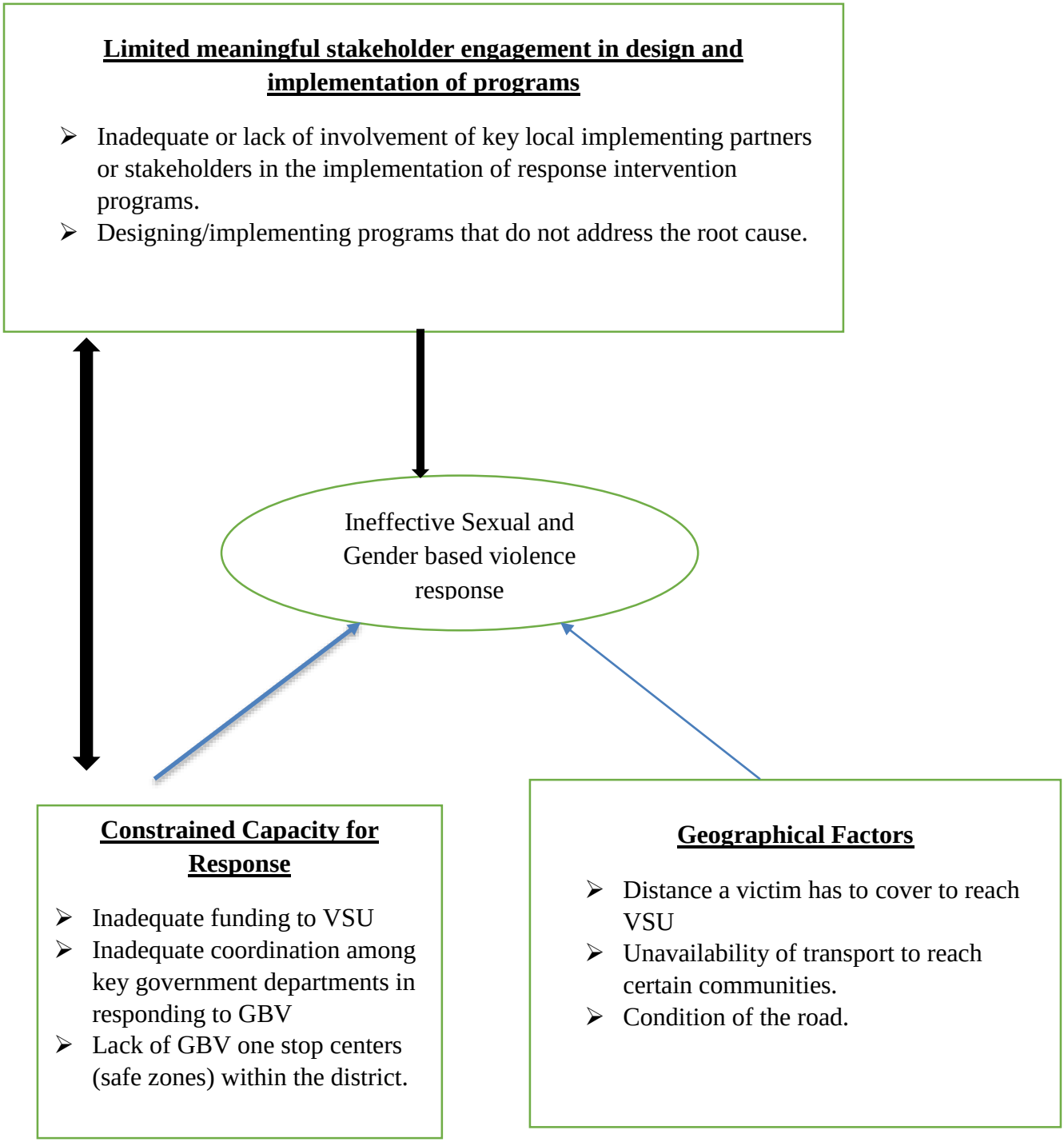
1.8 Conceptual Framework

A conceptual framework is a set of broad ideas and principles taken from relevant fields of enquiry and used to structure a subsequent presentation. It is a research tool intended to assist a researcher in developing an understanding of the situation under investigation. (Reichel & Ramey, 1987). This study will utilize the conceptual framework illustrated below in order to meet the objective of the research.

The study assumes that *ineffective programs* (lack of involvement of key local implementers in designing intervention programs, lack of involvement of traditional leadership in design and implementation of programs that do not address the real cause of sexual and gender-based violence), *Constrained capacity for response* (inadequate funding to victim support unit for responding to GBV cases, inadequate coordination among key local government departments e.g. health, MCDSS, VSU and education, in responding to cases of sexual and gender based violence, lack of sexual and gender based violence one stop centres) *geographical factors* (distance a victim covers to Victim support unit and hospital to report a case, availability of transportation, condition of roads), as independent variables, are important in influencing the escalation of gender based violence in Gwembe district.

DIAGRAM OF THE PROBLEM ANALYSIS

The diagram below shows a relationship of influence and effect between independent and dependent variables. Independent variables have a direct influence on the study variable.



1.9 Study Variables and Indicators

VARIABLE	INDICATORS	TYPE OF VARIABLE	CUT OFF POINT	QUESTION NUMBER
DEPENDENT VARIABLE				
Impact of GBV response interventions	High	Ordinal	GBV case reduced	18-19 (survivors' tool), 16-20 (implementers'' tool # 1), 13(implementers'' tool # 2),
	Moderate		GBV case still same	
	Low		GBV case increased	
INDEPENDENT VARIABLES				
Engagement of Local Stakeholder in Response interventions.	Yes	Categorical Binary	Yes	4-5, 14 (implementers'' tool # 1), 13(implementers'' tool # 2),
	No		No	
Designing and Implementing relevant GBV Response programs.	Very relevant	Ordinal	Very relevant	2-4 & 12 & 17
	Relevant		Relevant	
	Maybe		Maybe	
	I do not know		I do not know	
	Irrelevant		Irrelevant	
Coordination amongst key government departments in the district.	Very good	Ordinal	Satisfactory	4-8
	Good		Some	
	Below average		Nil	
Levels of Funding towards GBV response interventions	Adequate	Ordinal	Satisfactory funding	8-9
	Below average		Negligible funding	
	None at all		Lacking funding	
Distance to VSU	Very far	Ordinal	>10 km	2 & 3
	Far		5-10 km	
	Near		<5km	
State of road network for smooth travel	Good	Ordinal	Passable throughout the seasons.	4-5
	Bad		Passable only occasionally.	
	Impassable		Cut off during rainy season.	

1.9.1 Conceptual definition Of Terms

i. **Gender based violence:**

ii. Gender based violence refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms. (https://www.unhcr.org>gender-based-violence.html#:~:text=gender%2D)

iii. **Response:** Refers to a reaction to a stimulus or provocation. (Wiktionary)

iv. **Ineffective:** Is simply lacking in ability; incompetence or inadequate. (Livio English Dictionary 2015)

v. **Involvement:** Involvement is the act or instance of involving someone or something. (Merriam-Webster.com)

vi. **Designing:** This refers to practicing forethought. (Merriam-Webster.com)

vii. **Implementation:** Is an act or instance of implementing something: the process of making something active or effective. (Merriam-Webster.com)

viii. **Funding:** is the money from government or organization provided for a specific purpose. (htttps://www.macmillandictionary.com>)

ix. **Coordination:** Refers to the process of organizing people or groups so that they work together properly and well. (Merriam-Webster.com)

x. **GBV one stop center:** These are facilities that provide Multisectoral case management for survivors, including health, welfare, counseling, and legal services in one location. (endvawnow.org)

xi. **Distance:** Distance is the amount of space between two points, usually geographical points, usually (but not necessarily) measured along a straight line. (Livio English Dictionary 2015)

xii. **Transport:** means to carry or bear from one place to another; to remove; to convey. (English Dictionary)

xiii. **Road network:** This is a system of interconnecting lines and points on a map that visualize a system of streets for a certain area. (https://www.bria.com.ph>articles)

1.9.2 Operational Definition of Terms

i. OPERATIONAL: **Involvement of stakeholders:** In this study, stakeholder's involvement will be defined as the consideration and incorporation of key people's views and input in the response intervention against GBV. In the questionnaire, *Involvement of stakeholders:* will be dictated by questions 16 and question 3 on the KII questionnaire. The responded will answer Yes or No. On the KII questionnaire, the researcher will assess whether the *Involvement of stakeholders*, is in the designing, implementation or funding. Respondents who will answer yes to any of the respective questions will be graded as being adequately involved as stakeholders. Respondents who will answer No the respective questions will be graded as having inadequate or lack of stakeholder involvement.

ii. CONCEPTUL**:** Involvement is the act or instance of involving someone or something. (Merriam-Webster.com)

iii. OPERATIONAL: **Income levels:** in this study income level will be defined as the ability to generate sufficient funds monthly that will enable women and their families to have financial freedom needed to provide for their families and easily access institutions involved in the response interventions against GBV. In the questionnaire, income level of respondents will be dictated by questions 8. The researcher will grade income levels of respondents into Low, Moderate and Good based on their score. Respondents are to answer <K250, K250-K1000 and >K1000. Respondents who will respond <K250 to question 8 will be graded as having low income levels while respondents who will answer K250-K500 to question 8 will be graded as having moderate levels of monthly income while respondents who will answer >K1000 will be graded as having High levels of monthly income.

iv. CONCEPTUAL: Income level is the amount of monetary or other returns, either earned or unearned, accruing over a given period of time (Collins English Dictionary 2014)

v. OPERATIONAL: **Funding:** in this study funding will be defined as the monetary and logistical support rendered to institutions responsible for the response against Gender based violence in Gwembe district that will enable consistent response interventions. In the questionnaire, funding to institutions will be dictated by questions 16. The researcher will grade funding to institutions into none at all, below average and adequate based on their score. Respondents who answer none at all to question 16 will be graded as lacking support

in the response interventions towards GBV, while respondents who will answer below average to question 16 on KII questionnaire will be graded as having negligible funding towards the response interventions against GBV in Gwembe district and respondents who will answer adequate to question 16 will be graded as satisfactory support in the response interventions towards GBV.

vi. **Funding:** is the money from government or organization provided for a specific purpose. (htttps://www.macmillandictionary.com>)

vii. OPERATIONAL: Transport in this study will be defined as suitable, accessible and reliable means used by people to travel from one place to another and in this case, accessing institutions involved in the response interventions against GBV, and this serves as a determining factor for easy access to response interventions. In the questionnaire, transport will be dictated by questions 6. The researcher graded Motor vehicle, Motor bike, Ox-cart and Bicycle. Respondents who will answer motor vehicle to question 6 will be graded as having easiest, quicker and safer access to response interventions against GBV, conversely respondents that will answer Motor bike to question 6 will be graded as having easiest and quicker but risky access to response interventions against GBV owing to the mountainous terrain in Gwembe valley, and respondents who will answer bicycle to question 6 will graded as having slow or uneasy access to response interventions against GBV while respondents who will answer Ox-cart will graded as having slower or restricted access to response interventions against GBV especially if they stay > 5 km away from response intervention institutions.

viii. CONCEPTUAL **Transport:** means to carry or bear from one place to another; to remove; to convey. (English Dictionary)

ix. OPERATIONAL**: Distance** in this study will be defined as how far one lives away from institutions involved in the response interventions against GBV, this is inversely proportionate with the easiness or hardship associated with the distance one covers to access response interventions against GBV in Gwembe district. In the questionnaire distance will be dictated by question 3. The researcher graded distance to be covered by respondents as short, moderate and longer. Respondents who will answer less than 5km to question 3 will be graded as having covering a shorter distance to access the response interventions against GBV, respondents who will answer 5-15Km to question 3 will be

graded as covering moderate distance to access the response interventions against GBV, while respondents who will answer more than 15Km to question 3 will be graded as having to cover longer distance to access response interventions to GBV and are at high likelihood of having challenges in accessing the services.

x. CONCEPTUAL: **Distance:** Distance is the amount of space between two points, usually geographical points, usually (but not necessarily) measured along a straight line. (Livio English Dictionary 2015)

xi. OPERATIONAL**: Road network:** in this study will be defined as the state of usable roads as far as they enable or hinder smooth accessibility of sites or places involved in the response interventions against GBV. In the questionnaire road network will be dictated by question 4. The researcher will grade road network of the respondents as either good or poor. Respondents who will answer No to question 4 will be graded as having good road network and ultimately easy access to institutions involved in the response interventions towards GBV, while respondents that will answer Yes to question 4 will be graded as having poor road network and ultimately uneasy access to institutions involved in the response interventions towards GBV.

xii. CONCEPTUAL: **Road network:** This is a system of interconnecting lines and points on a map that visualize a system of streets for a certain area. (https://www.bria.com.ph>articles)

xiii. OPERATIONAL**:** **Relevance of response interventions**: in this relevance of response interventions will be defined as interventions that impactful, able to bring about the much desired result, which is reducing, or able to end the gender based violence vice in Gwembe district. In the questionnaire, relevance of response interventions will be dictated by question 17. The researcher will grade relevance of response interventions of respondents into very relevant, relevant, not sure and irrelevant based on their score.

xiv. CONCEPTUAL: **Relevance of response interventions** refers to the property or state of being relevant or pertinent. (Livio English Dictionary 2015)

1.10 Summary

This chapter has given a brief explanation the magnitude of GBV and how the impact of the response interventions would be assessed. The chapter has also shed light on the statement of the problem, purpose, objectives and research questions which guided the present study. Further, the chapter has provided the significance, delimitations, limitations and has discussed the conceptual framework/ analytical diagram of the relationship of variable and discussed key conceptual and operational definition of terms used in the study. It has also discussed the ethical considerations.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Overview

This section reviews the literature on the impact of the response interventions to gender-based violence against women and girls in Zambia and other parts of the world. The literature was reviewed according to the objectives of the study which were, limited meaningful stakeholder engagement in design and implementation of programs, constrained capacity for response and geographical factors on sexual and gender based violence response in Gwembe district.

The review also exposes the impact of the response interventions to gender-based violence against women and girls in Zambia and other parts of the world an evidence base of what has been done and achieved in relation to the effectiveness of the interventions, systematically, beginning globally then regionally and nationally or locally.

The review was extensive but focused to enhance conceptualization. Most of this information was taken from journals and by downloading using Google search engines.

2.2 Global perspective of the response against GBV

A WHO study estimates that 35 percent of women around the world, at some point in their lives, have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner. (Arengo et. Al 2014)

According to the United Nations Declaration of 1993, Violence against Women (VAW) a term often used interchangeably with Gender-Based Violence (GBV) constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms (UN, 1993). According to a World Health Organization (WHO) global survey and based on estimates from 79 countries, 30% of women reported having experienced physical and/or sexual intimate partner violence (IPV) at some point in their life.

While the prevalence was lower in high-income regions such as Western Europe and in the Western Pacific, the proportion of women reporting lifetime exposure was 37% in African, Eastern Mediterranean and South-East Asia regions. When the lifetime prevalence of IPV (physical and/or

sexual) and non-partner sexual violence is taken together, 45% of women in Africa are affected (WHO, 2013).

Historically, the World Bank invested relatively little to address GBV**.** The majority of the Bank's work on GBV consisting of analytical work, is supported by trust funds, and is geographically focused in contexts with particularly intense reports of GBV and is focused on responding to the problem rather than on prevention. (Alys M. Willman and Crystal Corman 2013) This review identified 38 World Bank operations active in 2008 or later, that either had an explicit focus on GBV or components on this topic, for an estimated $22.5 million in investment. However, attention to GBV is growing within the Bank portfolio and diversifying to new financial instruments**.** Since 2012, 12 new projects with an exclusive or priority focus on GBV, totaling $18.6 million, have been approved, including the Bank's first investment loan including SGBV prevention as a Project Development Objective (PDO), to Honduras. At the time of writing, a $75 million loan focusing on GBV in Africa's Great Lakes Region was under negotiation, and a State and Peace-Building Fund (SPF) proposal has been approved for a $12 million strategic initiative to pilot promising interventions and promote knowledge sharing across six fragile countries.

In another study by Erica Holzaepfel (2013) evaluating the effectiveness of gender-based violence prevention programs with refugees in Malaysia, employed a standard rapid appraisal of document, key informant interviews (KIIs), focus group discussions (FGDs), site visits, and direct observation of program activities. The Malaysia performance evaluation complemented and built upon, findings from the Desk Review Report submitted to DoS/PRM in July 2013 by providing primary information on best practices, lessons learned, and directions for future programming, support, and PRM engagement. The evaluation team identified the following five categories of target groups as data sources for the field evaluation: (Erica Holzaepfel 2013)

Part I: Achievement of program activities as defined in project proposals

Overall, the evaluation team found that PRM-funded NGO implementers successfully carried out the majority of proposed program activities, but the majority of activities involved responsive rather than preventive action and reflected a lack of understanding of GBV prevention-focused programming.

2. Were the objectives of the program based on evidence such as needs assessments or other forms of data?

The design of program objectives and activities was generally informed by one-off surveys and assessments; however, many of those assessments relied upon secondary data and were not designed or carried out by the NGO implementers themselves. None of the implementers had conducted baseline surveys or needs assessments among their target beneficiaries, nor had they determined the incidence or prevalence of GBV within the refugee community, the types of GBV experienced by refugees, the places and persons at highest risk of GBV (risk mapping), or the likely perpetrators. Erica Holzaepfel, identified a total lack of information about the level of GBV perpetrated by the police and other authorities, GBV committed by employers, the nature and extent of GBV among refugees and asylum-seekers in the forced labor market, the number of refugees and asylum-seekers forced by circumstances into survival sex, and the extent of needs and/or challenges faced by lesbian, gay, bisexual, transgender, intersex (LGBTI) refugees or asylum-seekers.

3. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs?

According to Erica Holzaepfel, Indicators used by NGO implementers to monitor program performance were weak (as noted in the Desk Review Report). Specifically, indicators were poorly designed and often included targets. Indicators should be neutral gauges of progress that can be compared against an objective or target. When used appropriately, targets can orient NGO implementers to tasks that need to be accomplished and provide guidance for monitoring whether or not program progress is being made on schedule and if results have been achieved over time. Generally speaking, implementers were confused about the difference between indicators and targets.

4. To what extent have men and boys been included in GBV awareness campaigns?

In general, all NGO implementers made efforts to engage males in GBV prevention and awareness activities; however, the implementers did not measure the impact of male engagement. Implementers reported recruitment of men and boys into GBV prevention activities as a key challenge in Malaysia due to cultural norms; they also reported difficulty with reaching most males over the age of 12 years, as their time is partially consumed with employment.

5: What were the short- and long-term outcomes of PRM-funded GBV prevention?

Understanding the short- and long-term outcomes of PRM-funded GBV prevention programs requires the measurement of outcome-level indicators such as the incidence of GBV, beliefs and

attitudes about GBV, and the prevention of GBV. However, NGO implementers do not collect information at the outcome level in practice, which renders systematic assessment of PRM-funded program outcomes impossible. Furthermore, PRM has been funding NGO implementers in Malaysia for only three years and long-term outcomes are yet to be determined. When asked about short- and long-term outcomes of NGO implementers' GBV prevention programs, respondents were unable to identify either.

2.3 Regional Perspective of the response against GBV

According Population Council (2008), in Kenya, 39% of women aged 15-49 have ever experienced physical violence since the age of 15, and one in five (21%) reported sexual violence. Given complicated stigma and reporting issues, it is likely that these national Demographic and Health Surveys (DHS) underestimate the true prevalence and incidence of violence.

An increasingly popular strategy for addressing GBV is through the establishment of one-stop centers' (OSCs), which provide integrated, multi-disciplinary services in a single physical location. The basic services of the OSC model in low resource settings in East and Southern Africa comprise health care (including psychosocial support), police and justice sector responses, and ongoing social support (Population Council, 2008; Keesbury & Askew, 2010). These are often provided within the context of a health facility due to the highly medicalized nature of the initial response services. Although a number of variations exist, at the core of this approach is a system of integrated medico-legal and counseling services. This system can either be physically co-located or can consist of a referral network that links the sectors.

According to Keesbury J and Askew I, (2010), the goals of this assessment were two-fold: First, to assess the effectiveness of different OSC models in terms of health and legal outcomes for survivors, and the cost-effectiveness of these models; and second, to identify lessons learned in OSC implementation with recommendations for both start-up and scale-up. The assessment was conducted in two in Kenya using a comparative case study approach to address the objectives. Three distinct OSC models were examined to determine the core strengths and weaknesses of each. Each OSC was considered as a ―case and multiple data sources were triangulated to assess their individual effectiveness, as well as the comparative effectiveness across sites. Fieldwork took

place in Kenya, from September-December 2011. Keesbury J. and Askew I, (2010). The central findings were as follows:

Kenya and Zambia are among the countries at the forefront of responding to SGBV in Africa through the establishment of OSCs. The assessment found that three OSC models have been implemented in the two countries. The first type is the health facility-based OSC, owned by a hospital, implemented by the health facility itself, and working directly with donors to establish and manage OSC functions that are integrated into the health facility ‘s routine activities. The second type is the health facility-based OSC, owned by a non-governmental organization (NGO), in which NGOs establish separate centres within existing health facilities to provide wrap-around services that strengthen and expand existing clinical services provided by the health facility. This is a common model across African countries. The third type is the stand-alone, NGO owned OSC which provides primarily legal and psychosocial support onsite, while survivors are referred elsewhere for health services.

The health facility-based, hospital “owned” OSC is best-suited for achieving the broadest range of health and legal outcomes for survivors. The assessment found that while the health facility-based OSCs ―owned‖ by hospitals offered healthcare services to survivors, the NGO-―owned‖ OSC models did not offer healthcare services to GBV survivors at their facilities (apart from psychosocial support), but relied on their referral systems. The NGO-owned OSCs did not have the adequate infrastructure, supplies, equipment and, relevant staff to offer clinical management of rape (or other kinds of violence) to survivors, whereas the hospital-owned OSCs did, enabling them to offer essential, clinical services to survivors. Keesbury J and Askew I, (2010)

GBV survivors perceived medical services provided by OSCs as effectively meeting their health needs. Acceptability of the medical services provided by health facility-based, hospital-―owned OSCs was high as they addressed survivors ‘need for privacy and confidentiality while seeking care. All survivors and caregivers who sought services in hospital-―owned OSCs were satisfied with providers ‘engagement with them, the type of questions asked, and the empathy shown by providers.

Integration of medico-legal services and police services enhances legal outcomes for survivors.

The findings show that despite many GBV cases being handled by the OSCs, few are processed through the criminal justice system.

Despite the establishment of OSCs, the prosecution and conviction of perpetrators remain a major challenge. Perpetrator prosecution and conviction require the cooperation of the police and survivors, but the assessment demonstrates that survivors face challenges in reporting cases to police stations, accessing legal services and representation in court. GBV stakeholders in Kenya reported that both survivors and police played a role in the delay of legal processes. Survivors who make a police report are expected to cooperate and assist the police during investigations, and to be willing to pursue the case up to its conclusion. Although in Kenya there have been efforts to involve the police through GBV training and the establishment of Gender Desks in police stations, survivors and stakeholders (including donor representatives who fund the OSCs, program managers and staff from each OSC, and external partners who work closely with the OSCs) felt that the effectiveness of these efforts is still limited.

Key stakeholders in Kenya consider the existing OSCs as inadequate in addressing the needs of GBV survivors holistically. None of the OSC models assessed was considered by key stakeholders as adequately meeting the needs of GBV survivors because they did not offer the complete range of medico-legal and psychosocial services under one roof. Although the hospital-owned OSCs excelled in the provision of clinical and psychosocial services, linkages to the legal and justice system remained weak. Stakeholders argued that without an integrated system, most clients will continue to receive clinical and psychosocial support, but the prosecution and conviction of perpetrators (for survivors that value this outcome) will not be realized. While the NGO-owned OSC models were perceived to have a strong legal component, their medical and referral systems were weak. Stakeholders argued that this hindered the models from achieving the objective of an OSC, which is to match medical, legal and psychosocial support services. It was noted that medical care is not only crucial for survivors 'healing process, but also for adducing evidence so as to ensure the prosecution and conviction of perpetrators.

A recent study conducted by the Tanzania Demographic Health Survey (TDHS) Report of 2010 makes it more explicit that, about 44% of the ever-married women age 15-49 experienced physical or sexual violence by an intimate partner. Of these, 39% of women had ever experienced physical violence while 20% of women reported having experienced sexual violence.

In a bid to address such challenges, Tanzania adopted devise of strategies. Such initiatives include undergoing criminal and civil justice reforms, mainly under the legal sector reform program (LSRP). This has resulted into amendment and enactment of substantive and procedural laws – some which addresses GBV and other gender-related challenges including HIV/AIDS; disability rights; and child rights. However, despite those and other notable legal reforms, the social and legal protections of vulnerable groups (women, children and others) seem to remain fragile.

According to TAWLA, (2014), this situation is partly attributed by presence of bad laws, some of which were named by the Nyalali's Presidential Commission as 40 bad laws about 22 years ago, but, have remained in force all the time.

As this analysis found out, some of the laws with weak or bad provisions or poor enforcement mechanisms as far as protection of vulnerable groups against GBV is concerned include: -

a) Constitution of the United Republic of Tanzania of 1977: Its bill of rights and duties (Articles 12 to 29 of this Constitution) bars discrimination on the basis of sex addresses only the de jure (letter of the law) and not the de facto (the practical effect on the law on the intended population). This falls short of the definition of CEDAW which requires state parties to address both the law and the practice.

b) Law Marriage Act, Cap. 29: still sanctions marriage of girls below 18 years contrary to a number of international human rights instruments on the rights of women. The law also sanctions polygamy and is silent on wife beating both of which are highly prevalent cultural practices.

c) Anti-Trafficking in Persons Act, 2008: Despite the magnitude of the problem, there are only few cases which have been investigated, prosecuted and adjudicated by the court regarding trafficking in persons in Tanzania. This study links this situation with low awareness about the law, lack of pro-active measures by law enforcers, etc.1 every country where reliable large-scale studies have been conducted, between 10 to 50 percent of women report they have been

Physically abused by an intimate partner in their lifetime (Ref.: Terry, Geraldine (2007). Women's Rights, Oxfam. Small guides to big issues. Page 122).

d) Penal Code, Cap. 16: It is relatively blunt on GBV in many ways including the fact that, it does not criminalize marital rape; does not contain a specific provision on GBV; some of the GBV offences, in particular, FGM are narrowly covered – left out women who are above 18 years.

e) Law of the Child Act, 2009: It does not state the legal age of marriage or prohibit child marriages and betrothals.

f) Employment and Labor Relations Act, 2004: There is no guideline for employers to adhere to while preparing the non-discrimination plan to guide them on how to maintain minimum standards for both men and women.

g) Land Act, 1999: The provision on presumed interest of spouses in land is not well implemented. If implement it would reduce if not end the problems which widows are facing by being evicted from the matrimonial especially in urban areas.

2.4 National Perspective of the response against GBV

GBV is widespread in Zambia and affects women and girls disproportionately, with the 2018 Zambia Demographic and Health Survey reporting that 36 percent of Zambian women have experienced physical violence at least once since the age of 15. (NAP-GBV, 2013)

Zambia being historically, one of the nations with high cases of SGBV in the region, has received recognizable support in the response against SGBV as is contained below: The Gender Cooperating Partners group meets on a monthly basis. Focus is on information sharing and coordination between the different gender and SGBV programmes.

According to (EU 2017) Action Document for Sexual and Gender-Based Violence (SGBV) Prevention and Support to SGBV Survivors in Zambia, the programme complements and builds on recognized gaps and best practices from other (SGBV) programmes, such as:

(1) The EU-funded GBV project with CARE (2006-2011). Set-up of the first One-Stop Centre in Zambia, handed-over to government in 2011, which are still running until now.

(2) The USAID and DFID's Stop GBV programme (2013-2018) – USD 27.4 million, implemented by NGOs, whose focus was on support to 16 district-level One-Stop GBV Centres, community mobilization, behaviour change communication, and training of paralegals and police.

(3) The UN joint programme on GBV (2012-2018) – USD 15.6 million, funded by Sweden and Ireland, implemented by different UN agencies, whose focus was on policy development, community mobilizations, support to fast-track courts, and capacity support to Ministry of Gender.

(4) The UNESCO's Strengthening Comprehensive Sexuality Education Program for young people in school settings (2013-2018) – with financial support from SIDA.

(5) The global Partnership on Ending Child Marriage – Funded by EU, DFID, CIDA; implemented by UNICEF. Focus on social empowerment.

(6) The World Bank's Girls' Education and Women Empowerment and Livelihood (GEWEL) programme (2015-2020) – USD 65 million. It focuses on economic empowerment of women and increased access to education for adolescent girls in 50 districts.

(7) The EU's Access to Justice Programme (PLEED) – Implemented with GIZ. Focus on policy guidance, institutional support and training to paralegals and the Victim Support Units. This programme will draw upon policy documents and training materials developed by these other programmes.

The EU (2017), further states that, ‘‘governments at the highest levels are dedicated to fight against GBV and in particular ending child marriage.’’ Anti-GBV legislation appears sufficient, but its implementation is hampered due to low budgetary allocations and weak institutional capacities. The Government has established two GBV fast-track courts to deal with the enormous backlog with the objective to establish these in all provinces. This is a unique approach to improving redress and prosecution of perpetrators of GBV. As they have only started operating in 2016, there is not yet sufficient proof of their effectiveness and efficiency. Furthermore, challenges are reported in terms of expensive set-up and high operational costs as well as retention of trained court staff.

Although various community sensitization and advocacy activities have been conducted in Zambia with Cooperating Partners' support, much more investment is needed to ensure lasting change in mind-set and behaviour. Globally it is recognized that more investments, interventions and resources are required to prevent GBV.

Fiona Samuels et al (2015), in a Baseline Study on Stamping Out and Preventing Gender Based Violence (STOP GBV) in Zambia, found that there is a critical need for GBV services -related both to prevention and to treatment or response. The data indicates that the STOP GBV Programme response has begun to have some positive effects, even during its inception period. In terms of the core STOP GBV Programme objectives, the response component, i.e., treatment and support to survivors, has gained more momentum than prevention in almost all the districts studied. During the fieldwork there was more evidence of medical, psychosocial, legal and safety support for GBV survivors, but limited outreach in terms of primary prevention activities including awareness-raising and improving the environment to respond to GBV.

The study also made the following observations; First, in terms of demand, even if services are available, GBV survivors are reluctant to report to or seek access to the services and there is a sense that a large majority of cases are unreported: The challenge is that although a number of

people have been reporting these cases, the majority still do not report so there is serious need to conduct a lot of sensitization in these communities (Mumbwa).

hile. Similarly, cases of child defilement are not reported in a timely fashion. These delays can be caused by transport problems but also because of parents not being aware of the need to report early. Similarly, even if cases are reported, they are often withdrawn, with women facing pressure from family members to do so.

There are three main challenges in relation to supply. First, infrastructure (particularly shelters) and transport were routinely seen to be critical gaps preventing not only the daily functioning of referral activities, but also longer-term sensitization initiatives. In all the districts the absence of safe homes and shelters meant that the safety of survivors could not be guaranteed, with churches, VSU and police offices often being used as temporary accommodation for the GBV survivors.

Secondly, the majority of services are primarily responsive. The only preventive measures for GBV referred to by study respondents were sensitization and community engagement initiatives. There was also limited awareness of the potential for broader community development initiatives focusing on livelihoods, social protection, child protection, or economic-strengthening for preventing GBV in the medium to longer term. Finally, and related to earlier points on making complaints and reporting incidents in a timely manner, police capacity to manage evidence, particularly DNA-related evidence, is a major obstacle in cases that proceed to prosecution.

According to the NAP-GBV (2008-2013) on "Support by the United Nations Country Team (UNCT) and Bilateral agencies," it outlines that UNFPA and UNICEF in other parts of the country are engaged in Multisectoral capacity building in Solwezi, where they have trained VSU officers, health care providers, magistrates, and local court judges. UNFPA has a long-standing comparative advantage in supporting the mainstreaming of GBV prevention in all its development assistance to government. Some of these include working through and within existing government institutions such as the GIDD, the ministry of health and also with NGOs to provide both financial and technical assistance. However, despite all the interventions that were done, it revealed the following challenges;

Lack of Reliable Data

There is a general lack of a GBV data collection and management systems that defines the kind of data to be collected and how this data will be managed. The situation is compounded by the lack of appropriate standardized data collection tools.

Insufficient policies and laws to address the problem:

There is no common definition of various gender-based violence offences, allowing judges wide interpretation, often leading to inconsistent court decisions and/or decisions that exemplify traditional attitudes that blame the survivor/victim.

Inadequate human Resources and capacity to manage cases of GBV

Relevant sectors do not have the technical, logistic, or financial and human resource capacity to adequately monitor and respond to the preventive as well and the management of GBV.

From the above literature review findings, it can be concluded that the response to SGBV has received remarkable funding for implementation of various programs ranging from prevention of cases and medical legal support to survivors as evidenced by the operationalization of OSCs. However, despite the response intervention, the vise has persisted.

In another study by Kasupe Chingumbe (2018) "Exploring coordination in a multi-agency partnership approach to prevention of gender-based violence in Zambia: lessons from the agencies‟ perception of the one stop center model of providing coordinated psycho-social and medical support to the victims" This study identifies factors that foster and hinders coordination among key agencies operating in One-Stop Centers in Zambia such as the police, health and social welfare that provide coordinated medical, social and legal services to the victims of gender-based violence. This primarily qualitative study collected data using interviews from participants selected from the key agencies operating from five One-Stop Centers in Lusaka province of the Republic of Zambia. Thematic content analysis was used to generate categories of data with similar meaning based on frequently recurring themes. Findings showed that although there is positive coordination among One-Stop Center agency players, there are a host of coordination challenges among them. The study ascertained that information sharing, communication, clearly defined goals and agreed outcome, increased knowledge of inter-disciplinary roles and inter-agency philosophy foster effective inter-agency coordination among key players in One-Stop centers. On the other hand, hindering factors such as lack of adequate resources, high attrition of staff, loss of membership interest and commitment, and lack of motivation and heavy reliance on unmotivated volunteers were identified as major setbacks to effective operation of One-Stop Centers in Zambia. The study further found that adequate allocation of resources, joint capacity building trainings and permanent attachment of staff to One-Stop Centers as panacea to the various challenges that encumber effective operation in One-Stop centers in Zambia.

Further, Fiona Samuels et.al (2015) in a Baseline Study: Stamping Out and Preventing Gender Based Violence (STOP GBV) programme in Zambia. Outlines that "The United States Agency for International Development (USAID) through PEPFAR, and UK Aid through the Department for International Development (DFID), have funded Word Vision, Zambia Centre for Communication Programme (ZCCP) and Women in Law for Southern Africa (WLSA-Zambia) to implement three projects under the umbrella of the Stamping Out and Preventing Gender-Based Violence (STOP GBV) Programme for a period of five years. The three STOP GBV Programme projects are: Survivor Support (World Vision), Prevention and Advocacy (ZCCP) and Access to Justice (WLSA-Zambia). The STOP GBV Programme worked in collaboration with the then Ministry of Gender and Child Development (MoGCD), the Ministry of Community Development Mother and Child Health (MCDMCH), the University Teaching Hospital (UTH), the Victim Support Unit (VSU), the Ministry of Health (MoH) and the Ministry of Chiefs and Traditional Affairs to institutionalize services for GBV survivors throughout government structures and to strengthen the quality of the GBV service referral mechanism.

The STOP GBV Programmes objectives include:

A. Survivor support

- Strengthen GBV survivor services
- Strengthen GBV response and coordination efforts
- Expand the engagement of boys and young men through sports

B. Prevention and advocacy

- Decrease social acceptance of GBV, enhance protective factors, and improve the enabling environment to respond to GBV

C. Access to justice

- Improve access to justice for adult and child survivors of GBV by building the capacity of GBV services as well as of policy-makers, police, courts, and community leaders in GBV management and implementation of laws.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter describes the research design and methodology that was used in assessing the impact of the response to Gender Based Violence (GBV) intervention in Gwembe District. It sets out various stages and phases that were followed in order to complete the study. It involves a plan for the collection, measurement and analysis of data. In this section the researcher identified the procedures and techniques that were used in the collection, processing and analysis of data.

Specifically, the following subsections are included; research design, target population, data collection instruments, data collection procedures and finally data analysis.

3.2 Research Design

A study design is the process that guides researchers on how to collect, analyze and interpret observations. It is a logical model that guides the investigator in the various stages of the research. This study was guided by a descriptive Cross-sectional Survey research design. In assessing the impact of the response to Gender Based Violence (GBV) intervention in Gwembe District, a descriptive cross-sectional survey was used over the period from August to September, 2022. The design enabled collection of data under natural setting, was relatively quicker and cheaper to undertake and the results were easily inferred to a larger population. Its application allowed for collection of quantitative data from the community. The descriptive part of this survey sought to obtain information that describes existing phenomena by asking individuals about their perceptions, attitude, behaviours or values to inform recommendations for policy. The descriptive approach also allowed the findings to be presented through simple statistics, tables, mean scores, percentages and frequency distributions.

3.3 Research Setting

Gwembe District is a tongue shaped stripe of land in the Southern Province of Zambia, and is in the valley of the Zambezi Escarpment, sharing boundaries with Siavonga, Monze, Pemba, Sinazongwe and Zimbabwe on the Lake Kariba. It is located at 160 38" south latitude and 270 46" East Longitude. It covers the total surface area of 3,879 km2 and is approximately 260 km from Lusaka the Capital City of Zambia. The district is located about 38 Km south-east of Monze town, off Monze-Livingstone road, via Chisekesi-Gwembe road, with its sub-Boma being 17 Kilometres from Chisekesi.

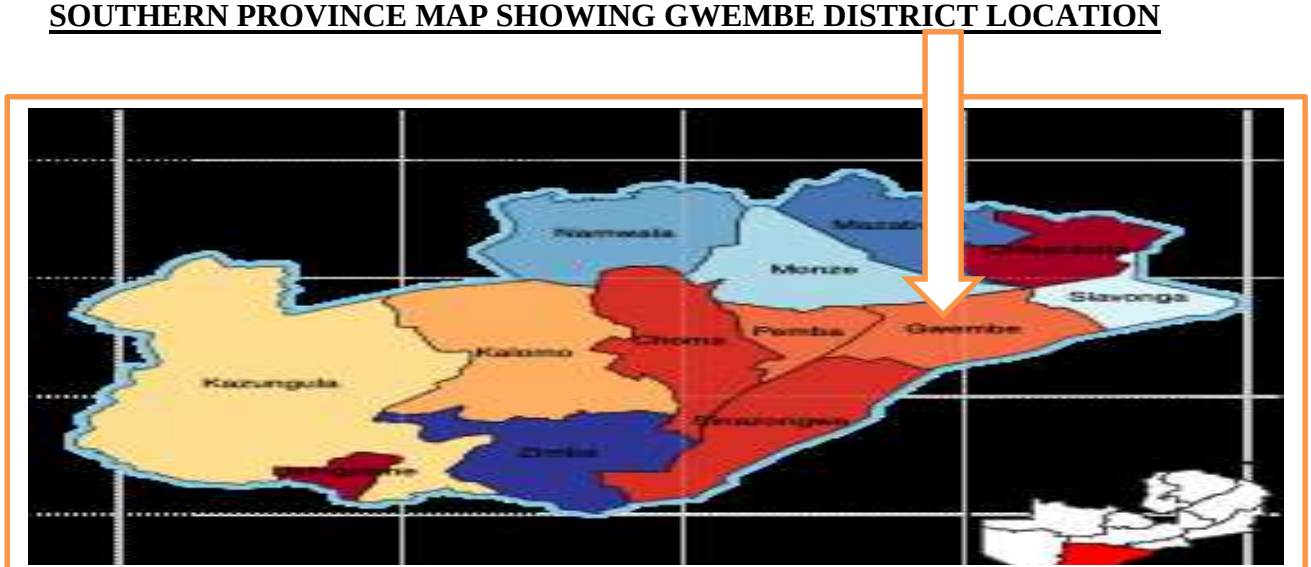
Gwembe district has an estimated total population of about 77,115 with the women of child bearing age (15 to 45years) being estimated at 17,246 for the year 2020 according to CSO statistics. Gwembe district is 830 meters above sea level and is characterized by extreme climate including severe multiyear droughts, coupled with periods of flooding and pest infestation which is generally the reason for the sustained food insecurities among the majority citizenry. However, the district

has recorded Uranium as an exploitable mineral commodity as well some oil deposits recently traced which is still undergoing studies. Its administrative functions are housed at Gwembe township (the plateau area) while the main commercial activities are based in the Gwembe valley at Munyumbwe some 32 km east of Gwembe town. One of the main agricultural activities in this district used to be cotton growing which was influenced by the presence of a cotton ginnery plant, which provided a lot of a lot of employment to the residents. As of 2017, the local people have focused on growing maize as a source of food and income. Most of the residents are subsistence. Gwembe district is divided into three areas, Gwembe Township, Munyumbwe and Chipepo. Politically, it is a district as well as a constituency, thus all three parts are represented by only one Member of Parliament and one council chairperson and several councilors from fourteen (14) wards namely: Chisanga, Sinafala, Jumbo, Kkoma, Chibuwe, Siampande, Kotakota, Luumbo, Bbondo, Chaamwe, Fumbo, Jongola, Lukonde and Kkole wards. In terms of general district administration**, t**he District Commissioner whose offices are based in Gwembe Sub-Boma administers Central Government programmes in the District, and this is where all Government Heads of Departments are also located.

Despite having major basic needs (clean water, health services and schools), Gwembe is still underdeveloped. There are no proper roads, no banks, and no refueling stations.

In terms of health care system, the district has two (2) Hospitals with nine (9) rural health Centre and nine (9) health posts. Due to lack of an operating theatre, the Gwembe township hospital refers some of its patients to Monze Mission Hospital, which is accessible by road via Chisekesi onto the Livingston-Lusaka road all year round. In terms of schools, the district has a total of 78 schools, 2 of whom are boarding schools, with 16 offering weekly boarding schools and the rest being primary schools.

SOUTHERN PROVINCE MAP SHOWING GWEMBE DISTRICT LOCATION



GENERAL PHYSICAL CHARACTERISTICS OF THE DISTRICT

The Zambezi valley, of which Gwembe forms a part, suffers a continuous drought phenomenon. For this reason, even in the years of good rainfall, belated and scanty amounts are experienced in Gwembe.

The terrain is mountainous with steep slopes, characterized by fast flowing, fast drying ravines undulating/ cascading rocky terrain which result in the land being highly erosive, leaving behind gullies. The effect on health care delivery is the toll it takes on the life expectancy of vehicles engaged in out-reach activities and frequency of replacing tyres, tubes, brake pads etc.

CLIMAT**E**

The climate of Gwembe is one of the hottest and driest in the country. The mean annual temperatures are about 25° C while the maximum temperature is about 40° C. The minimum temperature is above 10°C. The mean annual rainfall is about 700 mm. The rainy season starts from middle November and ends in the middle of March. This results in a long dry season from April to November. The rainfall is erratic and insufficient. Further, dry spells of up to three weeks during the rainy season are also common in the district and this adversely affects good harvest of the rain dependent crops.

TRADITIONAL LEADERSHIP

Gwembe District is mainly divided into two Chiefdoms. These are Chief Chipepo and Chief Munyumbwe. However, areas around Gwembe sub Boma are under chief Ufwenuka of Monze District. While Chief Munyumbwe's palace is based in Gwembe District, Chief Chipepo's Palace is in Siavonga. He administers his Chiefdom through his representative based at Chipepo village. There are a total of 315 Headmen under the two chiefs as follows: Chief Chipepo 194 and Chief Munyumbwe 121.

POVERTY SITUATION BY WARD

At ward level the indication is that the poorest ward is Sinafala followed by Fumbo, Jumbo/Kkoma and Siampande respectively at above 80.0% poverty levels. This revelation requires to be followed by strategic actions at ward level to reduce these levels closer to the provincial average of 65.5%. With the sex ratio standing at 48: 52 male to female, it is clear that development efforts at ward level should be targeted at responsive to the needs of women who are the majority in the district. (Gwembe District Commissioner's Office 2021)

Ward No	**Ward Name**	**Poverty Level (head count) (CSO 2007)**
1.	Chisanga	80.2%
2.	Sinafala	83.5%
3.	Sompani	82.7%
4.	Chibuwe	76.6%
5.	Siampande	82.4%
6.	Kota-Kota	75.8%
7.	Luumbo	80.1%
8.	Bbondo	77.5%
9.	Chaamwe	78.4%
10.	Fumbo	83.1%
11.	Jongola	80.7%
12.	Lukonde	70.9%
13.	Kkole	80.1%
14.	Jumbo/Kkoma	82.7%
District picture		**79.33%**

SOCIO-CULTURAL PROFILE

Primarily the Tonga people populate Gwembe District. The prominent socio-cultural practice is polygamy. It is not uncommon for a man to have three or four wives. Most females are married during their adolescent years. Children, a woman's sole means of acquiring the respect of her

husband and the community are considered the property of the mother. This results in extraordinarily large family sizes as wives compete for their husbands' affection.

Another largely negative result is that a large number of households in the valley are primarily female-headed with all of the inherent barriers to development. These suffer from poor health due to a physically exhausting workload and frequent pregnancies, lack of vital resources such as land, lack of self-confidence, inability to access credit where available, and little opportunity for formal education.

Women carry out the majority of agricultural and all domestic work. Land however, is the property of the husband and the husband's family. When a husband dies, therefore, his wives and children are immediately disenfranchised as his immediate family members gain control over his land and resources.

Large villages are rare. Rather, extended households comprised of three to four families and two to three generations, are randomly scattered throughout the valley making any type of service delivery expensive, Labor-intensive, and time consuming.

TRANSPORT

Road and water are two main forms of transportation used in the district. There are two main district roads namely the bottom road (D500 from Siavonga junction via Munyumbwe to Sinazongwe) and Mwanawasa road (D375 from Gwembe Township to Chipepo) both of which are gravel roads. There is currently 202 km of feeder roads – about 25% gravel and the rest being earth roads; about 150 km graveled district roads and 15 km unpaved township roads. The bottom road is being upgraded to bituminous road but the Gwembe – Chipepo road remains a gravel road that requires maintenance and even upgrading to a bituminous one as it is the main road used to link the district to other towns via the Lusaka – Livingstone road.

Lake Kariba is the only water body used for water transport. Unlike the roads, there is no form of commercial transport system on the water body within the district.

Emphasis would be placed on commercializing water transport and making it safer, construction of new roads as well as rehabilitation and maintenance of existing ones, upgrading of feeder earth

roads to gravel and rehabilitation of existing roads and bridges. There is also need to create a harbor at Chipepo. (Gwembe District Commissioner's Office 2021)

STRENGTH, WEAKNESSES, OPPORTUNITY AND THREATS (SWOT) ANALYSIS

Strengths:	**Weaknesses:**
The council has authority to formulate by-laws	Narrow revenue base
The council is given legal mandate to collect revenue and run businesses.	Inadequate vehicle, plant and relevant equipment
The council has the mandate to plan for its development (Planning authority status)	Insufficient Financial Management Systems
Commitment and dedicated staff	Lack of comprehensive information management system
Availability of assets	Un availability of good physical infrastructure such as roads, bridges, dams, banks, filling stations, storage facilities limit/ hinder participation of private investors and donors
Presence of qualified staff in all management positions.	Constant breakdown of utility vehicles
Opportunities:	**Threats**
Tourism potential	Lack of donor support to implement Socio – economic development programmes.
Plenty of land for developmental activities.	Floods and Droughts due to the valley characteristics of the area
Availability of natural resources like minerals, water, hills etc.	Inadequate funding from central government.
Political Stability	Political interference
Presence of NGOs, CBOs, FBOs	Inconsistencies in policy implementation
Government grants.	Out-dated laws
Availability of approved national Policies and programmes	Rural urban migration/ district to district emigration.
Goodwill of stakeholders and clients	

Favorable Investment policy	
Presence of line ministries in the district	

3.4 Study Population

A study population refers to the entire number of units under study or the whole or the inhabitants (Burns and Grove, 2005). Study population Consists of the target population and the accessible population. The study population for this study included all organizations/GBV programmes that are implemented in Gwembe district focusing on GBV as primary then secondary were women and girls who have experienced GBV.

3.3.1 Target Population

Target population included all organizations/GBV programmes that are implemented in Gwembe district as primary then secondary were women and girls who have experienced SGBV.

3.3.2 Inclusion Criteria

i. Women and girls aged 16 years and above who were residents of Gwembe and had either survived and witnessed GBV in Gwembe.
ii. Those who agreed to participate in the study were enrolled after signing an informed consent form
iii. Organizations implementing GBV programmes

3.3.3 Exclusion Criteria

Participants who were excluded from this study were

i. All women and girls who were non-residents of Gwembe district.
ii. Women and girls aged 16 years and above whom despite meeting the inclusion criteria, were are unwilling to give consent for the study.
iii. Organizations implementing GBV programmes but were unwilling to give consent for the study.

3.4 Sample Size

3.4.1 Sample Description

A sample is a small-scale representation- a kind of miniature model of population from which it is selected. The Krejcie and Morgan 1970 formula for a finite sample can be used to determine the sample size. Moreover, there are no general numerical directions in qualitative research (Guest et al., 2006, p. 60), clear rules or methods guiding the researcher how to obtain a properly sized sample (Kindsiko & Poltimäe, 2019; Lichtman, 2010; Malterud et al., 2015; van Rijnsoever, 2017). Patton (2002, p. 248) suggests orientation towards a minimal size, yet based on a "reasonable" coverage of the studied occurrence. Most researchers use the concept of "saturation", such concept being borrowed from grounded theory, in order to assess whether the sample size is proper or not (Malterud et al., 2015; Sandelowski, 1995). According to this principle, a sample has a proper size if it is large enough in order to answer the research's questions, to achieve the study's purpose. Saturation is achieved when any further data collection would not result in the identification of a new theoretical category that would be useful for understanding and explaining the analyzed occurrence.

For this study to have a reasonable sample and well saturated,

CALCULATION OF SAMPLE SIZE

The sample size can be determined by the formula $\mathbf{S=X^2\ NP\ (1-\ P)\ \div d^2\ (N-1)\ +X^2\ P\ (1-\ P),}$ by Daryle W. **M**organ (1970)

$$\mathbf{S=X^2\ NP\ (1-\ P)\ \div d^2\ (N-1)\ +X^2P\ (1-\ P).}$$

S= required sample size.

$\mathbf{X^2}$ **=** the table value of chi-square for 1 degree of freedom at the desired confidence level 1.96 x 1.96 = 3.8416

N **=** the population size. Seven (7) key local government departments that are involvement in the response against GBV, two (2) locally based NGOs, two traditional chiefs' representatives (for chief Munyumbwe & Chief Chipepo, and 14 elected Councillors plus 150 GBV survivors plus

(according data collected from the Gender and Domestic violence desk register for the period January-December 2020), giving a to a total of 175 units.

P = the population proportion (assumed to be .50 since this will provide the maximum sample size).

d = the degree of accuracy (5%) expressed as a proportion (0.05); it is the margin of error.

Thus **$S=X^2$ NP (1- P) ÷d^2 (N-1) +X^2P (1- P).**

$$S = 3.8416\ X\ 87(1 - 0.50) \quad \div 2.5(173) + 1.9208(0.50)$$

$$= 334.2192\ \frac{(0.50)}{0.4325 + 0.9604}$$

$$= \frac{167.1096}{1.3929}$$

$$= 119.97$$

Therefore: Desired Sample size is $\approx \underline{\underline{120}}$

The sample size was also verified by Raosoft ® an online Sample size calculator under the following parameters:

Margin of error at 5%

Confidence level of 95%

Population size of 100,000

Response distribution of 50%

3.5 Sampling Procedure

Sampling is a selection of a number of study units from a defined study population (Gosh 2013). The sampling for this study primarily started by selecting the organizations or CSO working on GBV or GBV interventions in Gwembe district, even if GBV is just a component of their broader services/interventions in Gwembe district they will be incorporated in the sample. Then a list of women who may be survivors of GBV was gotten from these organizations, that they have worked

with or just women whom they targeted as beneficiaries, this was the second layer of sampling. The third layer of sampling was one (1) program implementer/designer, such as a program director or program officer at organizations. This level further, included the following categories of respondents; all Heads of key government departments, which include; The Head of VSU at Gwembe district Police, District Health director, The District Community Development and Social Welfare Officer, The District Commissioner, and The District Education Board Secretary and will target community leaders (at least a representative of each of the two traditional leader) in Gwembe district as well The Area Ward Counselors. The above KIIs give a total of 25 participants.

At community or house hold level, the 95 GBV survivors were sampled through a Multistage sampling method to get clusters-primary sampling units, then secondary sampling units and ultimate sampling units as last as follows; firstly their wards of origin were identified and a representative sample out of 14 wards was obtained. Then a number of villages in each of the sampled wards were identified. Finally, a number of women and girls that had either survived or experienced GBV to be sampled from the selected villages were determined, giving a total of 95 GBV survivors. If households of GBV survivors were adjacent to each other in a village with more survivors, the household in between were skipped. Only one GBV survivor was obtained from each household in the sampled villages.

3.6 Instruments for Data Collection and Analysis

For this study, the researcher employed the following data collection tools to gather necessary data: *One-on-one interviews*, which was needed to gather highly personalized information. The researcher also used self-administered semi-structured *surveys and questionnaires*, which enabled participants to answer freely at length where necessary, aside from information elicited from a set number of responses. Further the researcher, used *Focus group discussions* where necessary to save on time. Observations are another data collection method that was used in this study, in which the researcher observed subjects in the course of their regular routine, to take valuable field notes for record.

3.6.1 Validity of the Data Collection Tool

Validity is defined as "the degree to which an instrument measures what it is intended to measure" (Polit and Hunger, 2001). In this study, validity was measured by conducting an extensive literature review on the variables of interest. The researcher checked the questions in the interview schedule and ensured that the same sets of questions were used on all the respondents as clear as possible.

3.6.2 Reliability of the Data Collection Tool

Reliability in a quantitative study is the stability of the measuring instrument over time and it is the measure of the extent to which random variation may have influenced stability and consistency of the results. The study instruments were pre-tested in Chisekesi area of Monze district before actual use in the study setting in order to test for Reliability. The results from the pilot study were used as base line data to test reliability.

3.6.3 Pretesting Research Instruments

The researcher pre-tested the instruments via a pilot study, which is defined as "a small scale study that is conducted before the main study on a limited number of subjects from the same population as that intended for the main study" by (Dempsey and Dempsey, 2002). The pilot study constituted about five (5) respondents conducted in Chisekesi area of Monze district due to the similarities it has with the study setting, as they are adjacent neighboring places. The respondents were selected using purposeful sampling. The purpose of the pilot study was to test the data collection tools, detect flaws such as ambiguity and illogically sequenced questions and make revisions to strengthen the methodology (Polit and Hungler, 2008). The pilot study aimed at assessing whether the variables would be observable and measurable.

3.7 Data Collection Procedure

In this research study, data collection technique used FGDs-interviews, direct observation of program activities, site visits, and KIIs to collect Primary data.

Further, key data was collected using the semi-structured self-administered questionnaires comprising both open and close ended questions to interview eligible GBV survivors, government

representatives, key implementers, local leadership, policy and other service providers. The semi-structured interviews and focus group discussion were used to encourage the respondents to give an in-depth and felt response without feeling held back in revealing of any information documents and artifacts.

Every file for the participant that was captured in the study was marked with a unique identifier after interviews to ensure there was no repeat interview on the same clients in the subsequent visit. The stickers were removed immediately after the intended sample was reached.

3.8. Plans for Data Processes and Analysis

Data analysis is "the systematic organization and synthesis of research data, and the testing of research hypotheses using those data" (Polit and Hungler, 2001). After data collection, the questionnaires were sorted out according to questions. The responses were verified, coded and plotted on a data master sheet to allow for easier analysis. In this study the researcher analyzed the data from open ended questions using the Statistical Package for Social Sciences (SPSS) software for windows 22.0 (2014version). Then the data was displayed in frequency tables, and numerical descriptions to show the relationship of variables. Chi-square was used to compare observed frequencies with expected frequencies and analyzing data where one has counted the frequency (number of cases or respondents) in different categories.

3.9. Plans for Dissemination of Findings

Dissemination of findings is a systematic plan of how the research findings were communicated. After analyzing the data, the researcher wrote a report for the purposes of communicating and submitted to the supervisor. The findings would be disseminated to the district administration and cooperating partners especially UNFPA via a meeting held in order to update them on the findings. Copies of the research report would be submitted to the Unza school of Public health and Unza Library for future references.

3.10 Ethical Considerations

During the research the researcher was able to put into considerations the moral standards of all the methods used at every stage of the research. The study was approved by DRGS committee

with **REF NO. HSSREC-2022-July-065**. Consent was also obtained from participants before they participated in the study and they had the right to understand what the researcher was doing. Issues of confidentiality were assured to participants in that none of their views would be shared without their concern. The questionnaires had no names of the respondents.

3.11 SUMMARY

This chapter had discussed the research design used which is the descriptive cross sectional survey. It has also looked at the study population, sample size and the sampling procedure. The instruments for data collection which are the semi-structured and interview guide. Lastly the data collection procedure and how data has been analyzed has also been discussed.

CHAPTER FOUR

RESULTS

4.1 Overview

This study sought to assess the effectiveness of the response to Gender based violence interventions against women and girls in Gwembe district. Furthermore, it sought to establish the influence of limited meaningful stakeholder engagement in design and implementation of programs, constrained capacity for response and geographical factors on sexual and gender based violence response in Gwembe district.

4.2 Sample Size and Characteristics of the Sample

Research respondents consisted of 102 women who had survived or experienced gender based violence within Gwembe district, and from the implementers category, respondents included seven (7) heads of key government departs at Gwembe district, two (2) civic leaders from local government, four (6) traditional leaders (headmen/woman, and two (2) respondents from the implementing non-governmental organizations, to have a total 15 respondents from the implementers category, giving a total of sample size of 119 out of 120 respondents, since one KII among the government departments did not participate in the study.

4.3. Results

4.3.1 Demographic Characteristics Of Gbv Respondents In Gwembe District

The first objective of this study was to determine whether Geographical factors: Distance that a GBV survivor/ victim has to cover to reach VSU, unavailability of transport to reach certain communities, and the condition of road network impacted gender based violence in Gwembe district. The hypothesis for the Geographical factors variable was that; Distance that a GBV survivor/ victim has to cover to reach VSU, Unavailability of transport to reach certain communities, and the Condition of road network had an impact on gender based violence in Gwembe district. The results are tabulated below:

TABLE 1 SHOWING AGE IN RELATION TO SURVIVING/EXPERIENCING GBV (n = 102)

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	16-20 Years	4	3.9	3.9	3.9
	21-30 Years	31	30.4	30.4	34.3
	31-40 Years	39	38.2	38.2	72.5
	41 and Above	28	27.5	27.5	100.0
	Total	102	100.0	100.0	

Statistics

Age

N	Valid	102
	Missing	0

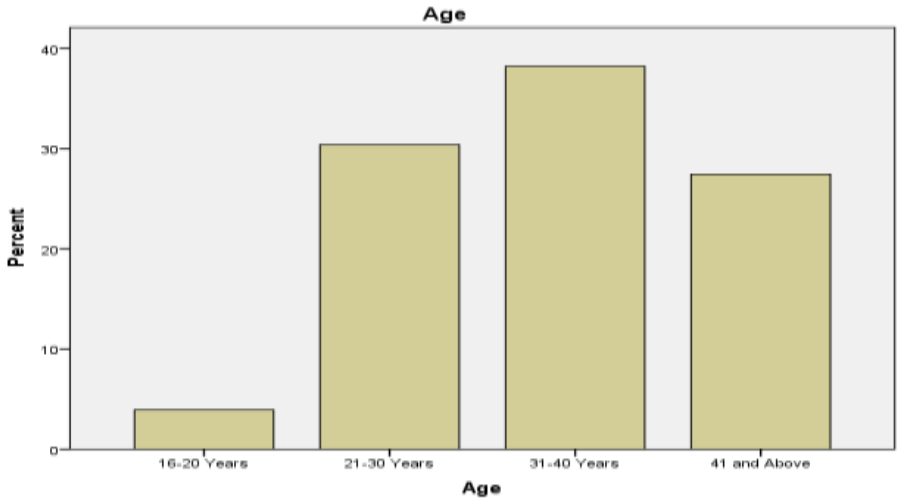


Table 1 above indicates that the majority of women (39) 38.2% of 102 women who survived or experienced GBV were aged between 31 and 40 years, followed by (31) 30.4% of 102 women who survived or experienced GBV being aged between 21 and 30 years while only (04) 3.9% of who survived or experienced GBV were aged between 16 and 20 years.

TABLE 2: CROSS TABULATION SHOWING RELATIONSHIP AMONG WOMEN THAT SURVIVED ANY FORM OF GBV VS HIGHEST LEVEL OF EDUCATION AND MONTHLY INCOME

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Survived any form of GBV * highest level of education * Monthly income	102	100.0%	0	0.0%	102	100.0%

Survived any form of GBV * highest level of education * Monthly income Cross tabulation

Count

Monthly income			Highest level of education			Total
			Never been to School	Primary	Secondary or Higher	
<K250	Survived any formofGBV	Yes	4	19	9	32
		No	3	6	5	14
	Total		7	25	14	46
K250-K1000	Survived any formofGBV	Yes	3	4	6	13
		No	1	5	6	12
	Total		4	9	12	25
>K1000	Survived any formofGBV	Yes	3	3	18	24
		No	0	2	5	7
	Total		3	5	23	31
Total	Survived any formofGBV	Yes	10	26	33	69
		No	4	13	16	33
	Total		14	39	49	102

Table 2 above indicates that the majority of women (33) 48% of 69 women who ever had survived GBV in Gwembe district had tertially level of education, while (26) 38% women who ever had survived GBV in Gwembe district had primary level of education and only (10) 15% women that ever had survived GBV in Gwembe district had never been to school.

The cross tabulation above, indicates that for GBV survivors earning K250.00 or less as their monthly income level (19) 59% of the 32 had only primary level of education, while (9) 28% had tertially education and only (4) 13% of 32 GBV survivors never had been to school.

In addition, for GBV survivors earning K1, 000.00 and above as their monthly income level (18) 75% of the 24 tertially level of education, while those with only primary level of education were (3) 12.5% of 24 same as the GBV survivors that had never been to school were (3) 12.5%.

As for GBV survivors earning between K250.00 to K1, 000.00 as their monthly income level (6) 46.2% of the 13 had tertially level of education, however, those with only primary level of education were (4) 31% of 13, while the GBV survivors that had never been to school were (3) 23.1%.

TABLE 3: SHOWING MONTHLY INCOME FOR GBV SURVIVORS IN GWEMBE DISTRICT (N=102).

Monthly income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<K250	46	45.1	45.1	45.1
	K250-K1000	25	24.5	24.5	69.6
	>K1000	31	30.4	30.4	100.0
	Total	102	100.0	100.0	

The frequency table 3 above indicated that the majority (46) 45.1% of 102 GBV survivors earned K250.00 or less, and (31) 30.4% of 102 survivors earned >K1, 000.00 while survivors who earned between k250.00 - k1, 000.00 were (25) 24.5%.

4.3.2 How Geographical Factors Impacted GBV in Gwembe District

TABLE 4: SHOWING DISTANCE AND MOST CONVINIENT MODE OF TRANSPORT (N=102).

Location * Most convenient mode of transport Cross tabulation

Count

		Most convenient mode of transport			Total
		Motor Vehicle	Motor Bike	Bicycle	
Location	Less than 5 KM	70	1	1	72
	Between 5 and 15 KM	8	0	0	8
	Over 5 KM	10	1	11	22
Total		88	2	12	102

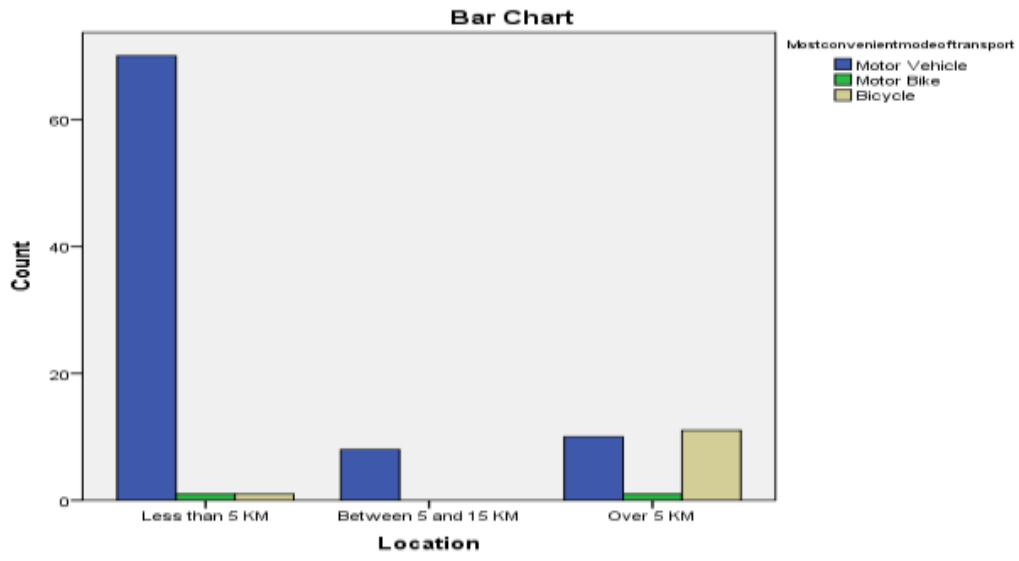
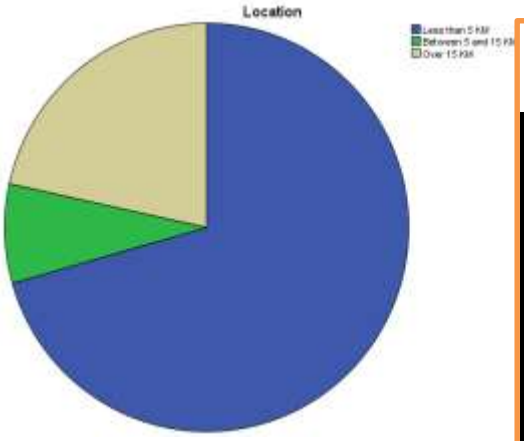


Table 4 above indicates that the majority of women (70) 97.2% of 72 women who lived within 5km radius used motor vehicle as the most convenient mode of transport and only (1) one woman used a bicycle and another one used motorbike as the most convenient mode of transport. While women that live between the radiuses of 5-15 km, (8) 100% of 8 women used motor vehicle as the most convenient mode of transport but none used bicycle or motor bike. For women that live beyond the 15 km radius, (11) 50% of 22 women used Bicycle as the most convenient mode of transport and (10) 45% women that that lived beyond 15km radius used motor vehicle as the most convenient mode of transport, but only (1) 5% used motor bike as the most convenient mode of transport.

TABLE 5: SHOWING DISTANCE AND MOST CONVINIENT MODE OF TRANSPORT (N=102).



Location

		Frequency	Percent	Valid Percent	Cumulative
Valid	Less than 5 KM	72	70.6	70.6	70.6
	Between 5 and 15 KM	8	7.8	7.8	78.4
	Over 15 KM	22	21.6	21.6	100.0
	Total	102	100.0	100.0	

Table 5 above indicates that the majority of women (72) 70.6% of 102 women who survived GBV lived within 5km radius, and survivors that lived beyond 15 km accounted for (22) 21.6 %, but survivors that lived between the 5-15 km were (8) 7.8.

TABLE 6: SHOWING STATE OF THE ROAD NETWORK HINDER SMOOTH TRAVEL (N=102).

State of the road network hinder smooth travel

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	29.4	29.4	29.4
	No	72	70.6	70.6	100.0
	Total	102	100.0	100.0	

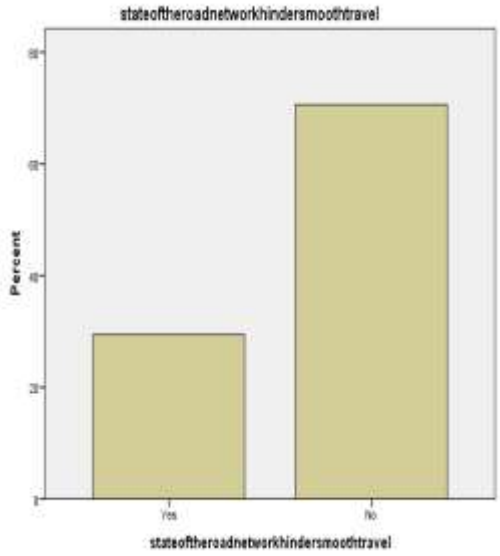


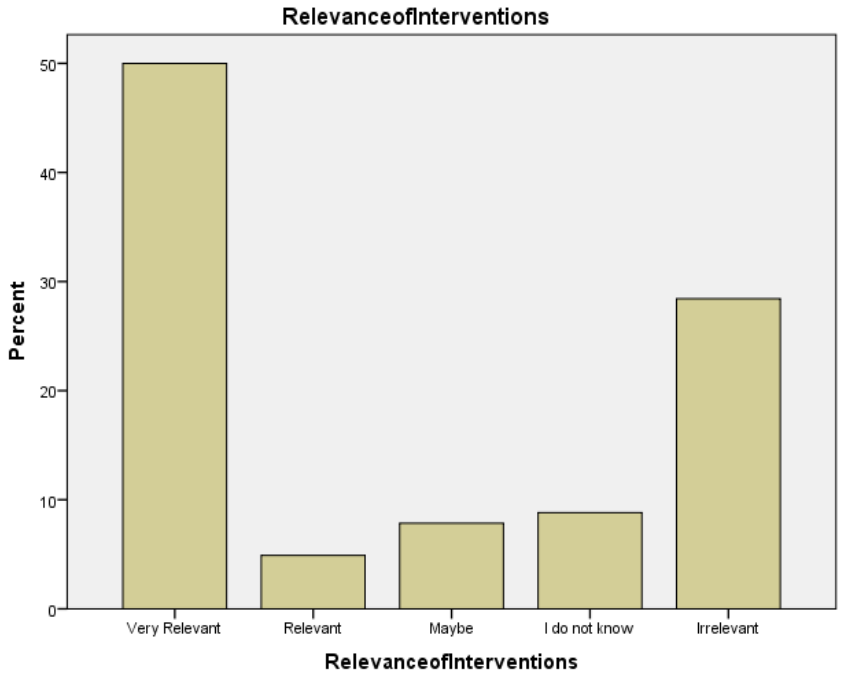
Table 6 above shows that the majority of women (72) 70.59% of 102 women who experienced or survived GBV in Gwembe district indicated that the state of their road network does not hinder smooth travel with regards to accessing response interventions against GBV, while (30) 29.41% of 102 GBV survivors indicated that the state of their road network hindered smooth travel with regards to accessing response interventions against GBV.

4.3.3 How Stakeholder Engagement Factors Impacted GBV

The second objective of this study was to determine whether: limited meaningful stakeholder engagement in design and implementation of programs, Inadequate or lack of involvement of key local implementing partners or stakeholders in the implementation of response intervention programs and Designing/implementing programs that do not address the root cause impacted gender based violence in Gwembe district. The hypothesis for the stakeholder engagement variables was that limited meaningful stakeholder engagement in design and implementation of programs, Inadequate or lack of involvement of key local implementing partners or stakeholders in the implementation of response intervention programs and Designing/implementing programs that do not address the root had an impact on gender based violence in Gwembe district. The results are tabulated below:

TABLE 7. SHOWING RELEVANCE OF GBV INTERVENTIONS IN GWEMBE (N=102)

```
FREQUENCIES VARIABLES=Relevance of Interventions
  /BARCHART PERCENT
  /ORDER=ANALYSIS.
```



Statistics

Relevance of Interventions

N	Valid	102
	Missing	0

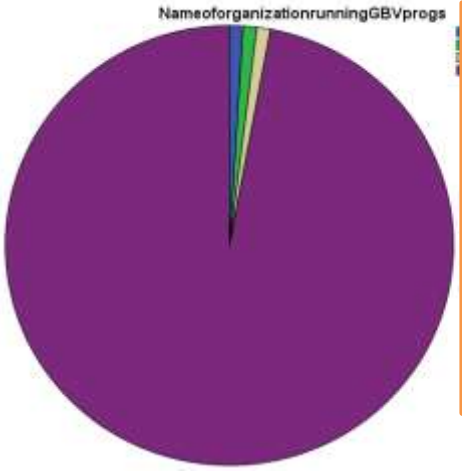
Relevance of Interventions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Relevant	51	50.0	50.0	50.0
	Relevant	5	4.9	4.9	54.9
	Maybe	8	7.8	7.8	62.7
	I do not know	9	8.8	8.8	71.6
	Irrelevant	29	28.4	28.4	100.0
	Total	102	100.0	100.0	

Table 7 above shows that (51) 50% of the 102 women who survived or experienced GBV in Gwembe district indicated that the response interventions against GBV were very relevant, (5) 4.9% of 102 respondents categorized the response interventions as relevant, yet (8) 7.8% of 102 respondents indicated that maybe GBV response interventions are relevant. While (9) 8.8% of the 102 women who survived or experienced GBV in Gwembe district indicated that they do not know,

however, (29) 28.4% of 102 women who survived or experienced GBV in Gwembe district disclosed that the response interventions against GBV in Gwembe district were irrelevant.

TABLE 8. SHOWING NAMES OF ORGANIZATIONS RUNNING GBV PROGS (N=102)



Name of organization running GBV programmes

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	UNFPA	1	1.0	1.0	1.0
	YWCA	1	1.0	1.0	2.0
	World Vision	1	1.0	1.0	2.9
	Any other	99	97.1	97.1	100.0
	Total	102	100.0	100.0	

Table 8 above illustrates that the majority (99) 97.1% of 102 women who experienced or survived GBV in Gwembe district attributed the response interventions to any other implementers while YWCA, UNFRPA and world vision all had only (1) 1% of 102 women attributing the response interventions to these institutions.

TABLE 9. SHOWING HAVING HEARD OF GBV PROGRAMS AND EVER ATTENDING SENSITIZATION MEETING AGAINST GBV IN GWEMBE (N = 102).

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Ever head of programs aimed at preventing GBV * Ever attended any meeting on GBV	102	100.0%	0	0.0%	102	100.0%

HBV * Ever attended any meeting on GBV Cross tabulation

Count

	Ever attended any meeting on GBV		Total
	Yes	No	

Ever head of programs aimed at preventing GBV	Yes	34	25	59
	No	13	29	42
	6.00	1	0	1
Total		48	54	102

Table 9 above shows that that the majority (34) 58% of the 59 women who had ever heard of GBV programs in Gwembe district, attended at least any sensitization meeting on GBV in Gwembe district, but (13) 31% of 42 women who had ever survived or experienced GBV in Gwembe district that attended any of the meetings aimed at preventing GBV had never heard of programs aimed at preventing GBV in Gwembe district. While (29) 69% of 42 women who had never attended any GBV meeting in Gwembe district neither had ever heard of programs aimed at preventing GBV in Gwembe district.

TABLE 10. SHOWING WHETHER WOMEN REALIZED THAT CORPORAL PUNISHMENT IS ABUSE (18B) BY HAVE GBV CASES DECLINED (18A) (N = 102).

```
CROSSTABS

  /TABLES=womenrealisedcorporalpunshmentisabuse18b BY HavGBVcasesdeclined18a
  /FORMAT=AVALUE TABLES
  /CELLS=COUNT
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
womenrealisedcorporalpunshmentisabuse18b * HavGBVcasesdeclined18a	102	100.0%	0	0.0%	102	100.0%

Women Realized Corporal Punishment Is Abuse 18b* Have GBV Cases Declined 18a Cross Tab

		Have GBV cases declined18a		Total
		Yes	No	
Women realized corporal punishment is abuse18b	Yes	76	16	92
	No	7	3	10

Total	83	19	102

Table 10 above shows that the majority (76) 92% of the 83 women who had survived or experienced GBV in Gwembe district, disclosed that women in Gwembe district had realized that corporal punishment (physical violence) is a form of GBV and also attested that GBV cases in Gwembe district had GBV cases had declined as compared to the past years, while only (16) 17.4% of 92 (13) women who had realized that corporal punishment (physical violence) is a form of GBV believe that GBV cases in Gwembe district had not declined. However, of the 10 women that disclosed that women in Gwembe district had not realized that corporal punishment was a form of GBV, 7 of them indicated that GBV cases had declined.

TABLE 11. SHOWING WHETHER SURVIVORS WERE INTIMIDATED BY VSU OFFICERS (19A) BY EFFORTS TO BRING PEPERTRATOR TO BOOK MADE (19B)

```
CROSSTABS
  /TABLES=wereyouintimidatedbyVSUofficers19a                    BY
Effortstobringpepertratortobookmade19b
  /FORMAT=AVALUE TABLES
  /CELLS=COUNT
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
wereyouintimidatedbyVSUofficers19a * Effortstobringpepertratortobookmade19b	102	100.0%	0	0.0%	102	100.0%

Were you intimidated by VSU officers19a * Efforts to bring perpetrators to book made19b Cross tabulation

Count

	Efforts to bring perpetrators to book made19b		Total
	Yes	No	

Were you intimidated by VSU officers 19a	Yes	14	2	16
	No	2	84	86
Total		16	86	102

Table 11 above illustrates that of the 86 women who had survived or experienced GBV in Gwembe district and had not been intimidated by VSU officers at Gwembe police, the majority of them84 (98%) of 86 disclosed that no efforts were made to bring the GBV perpetrators to book, while only (2) of 86 women who were not intimidated by VSU officers disclosed that efforts were made to bring the perpetrator to book.

TABLE 12. SHOWING WHETHER VSU REFERED SURVIVORS FOR MEDICAL CHECK-UP * EFFORTSTOBRINGPEPERTRATORTOBOOKMADE (19b)

```
CROSSTABS
  /TABLES=Vsuhospitalformedicalcheckup                                    BY
Effortstobringpepertratortobookmade19b
  /FORMAT=AVALUE TABLES
  /CELLS=COUNT
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
VSU hospital for medical checkup * Efforts to bring perpetrators to book made19b	102	100.0%	0	0.0%	102	100.0%

From VSU to hospital for medical checkup * Efforts to bring perpetrators to bookmade19b Cross tabulation

Count

	Effortstobringpepertratortobookmade19b	Total

		Yes	No	
VSU hospital for medical checkup	Yes	10	0	10
	No	6	86	92
Total		16	86	102

Table 12 above illustrates that (10) 100% of 10 GBV survivors that visited VSU, and were referred to hospital for medical report/check-up all the 10 reported that effort was made to bring the perpetrator to book. While of the 92 survivors that were not referred by VSU to hospital for medical report/check-up, (6) 6.5% indicated that efforts were made to bring the perpetrator to book.

4.3.4 How Constrained Capacity for Response Factors Impacted GBV

The third objective of the study which mainly applies to GBV response implementers (government departments, non-governmental organizations, traditional leadership) seeks to examine whether constrained capacity for response factors impacted GBV response: Inadequate funding to VSU, Inadequate coordination among key government departments in responding to GBV, Lack of GBV one stop facility impacted gender based violence in Gwembe district. The hypothesis for the constrained capacity for response factors impacted GBV response factors variable was that; Inadequate funding to VSU, Inadequate coordination among key government departments in responding to GBV, Lack of GBV one stop facility impacted Gender Based Violence in Gwembe district. The results are tabulated below:

TABLE 13. SHOWING LEVEL OF FUNDING TOWARDS GBV RESPONSE (N=17).

VARIABLE: ↓	ADEQUATE	BELOW AVERAGE	NOT AT ALL	TOTAL
LEVEL OF FUNDING FOR GBV RESPONSE	0 0%	06 40%	11 64.7%	17 100%
TOTAL	**(0) 0%**	**(6) 35.3%**	**(9) 64.7%**	**17**

Table 13 above shows that none 0% of 17 implementers indicated that they had received adequate funding towards GBV response. While the majority (11) 64.7% of implementers indicated that they received no funding at all for response towards GBV interventions. And (6) 40% of 17 implementers disclosed that they received below average funding at towards GBV interventions.

TABLE 14. SHOWING LEVEL OF COORDINATION (BEING CONSULTED BY OTHER IMPLEMENTERS (N=17).

VARIABLE: HAVE YOU EVER BEEN CONSULTED BY OTHER IMPLEMNTERS?	Level of collaboration			TOTAL
	Program implementation	Program design	Program funder	
Yes 12	09 (9) 75%	03 (3) 25%	0 (0) 0%	12 71%
No 05				(05) 29.4%
TOTAL	(09) 75%	03 (6) 25 %	(0) 0%	17 100%

Table 14 above shows that (12) 70.6% of 17 implementers indicated that they had been consulted in activities towards GBV response in Gwembe district. Of the 12 that were consulted, (9) implementers indicated that the collaboration was at the level of program implementation, and (3) 25% of the 12 implementers stated that they were consulted at the level of program design, while 5 implementers indicated that they were not consulted at all.

TABLE 15. SHOWING LEVEL OF COORDINATION (CONSULTING OTHER IMPLEMENTERS (N=17).

VARIABLE: HAVE YOU EVER CONSULTED OTHER IMPLEMNTERS?	Level of collaboration			TOTAL
	Program implementation	Program design	Program funder	
Yes 07	05 71.4%	01 14.3%	01 14.3%	07
No 10				10
TOTAL	(05) 71.6%	01 (61) 14.2 %	01 (61) 14.2 %	17 100%

Table 15, above shows that the majority (10) 59% of 17 implementers indicated that they had never been consulted at any level by any other implementer in activities towards GBV response in Gwembe district. While (5) 71.4% of 7 implementers that had been consulted, indicated that their engagement was at the level of program implementation, while those engaged at the level of program design and funding were 1 or 25% respectively.

TABLE 16. SHOWING RATE OF COLLABORATION AMONG IMPLEMENTERS (N=17).

VARIABLE: ↓	VERY GOOD	GOOD	BELOW AVERAGE	TOTAL
RATE OF COLLABORATION	09 53%	03 18%	05 29%	17 100%
TOTAL	(09) 53%	(03) 18%	(05) 29%	(17) 100%

Table 16, above shows that the majority (9) 53% of 17 implementers rated collaboration activities towards GBV response in Gwembe district as being very good, and (3) 18% of 17 implementers rated the collaboration as good, while (5) 29% of 17 implementers rated the collaboration activities towards GBV response in Gwembe district as below average.

TABLE 17. SHOWING RELEVANCE OF GBV INTERVENTIONS IN GWEMBE (N=17).

VARIABLE: ↓	Very Relevant	Relevant	Maybe	I do not know	Irrelevant	Total
RELEVANCE OF GBV INTERVENTIONS	08 47.%	06 35.3%	01 5.9%	01 5.9%	01 5.9%	17 100%
TOTAL	08 47.%	06 35.3%	01 5.9%	01 5.9%	01 5.9%	17 100%

Table 17, above shows that the majority (8) 47% of 17 implementers rated Relevance of response interventions against GBV in Gwembe district as being very relevant, and (6) 35.3% of 17 implementers rated the Relevance of response interventions as relevant, while only 1 implementer rated Relevance of response interventions against GBV in Gwembe district as maybe, I do not know or irrelevant respectively.

TABLE 18. SHOWING WHETHER WOMEN HAVE REALIZED THAT CORPORAL PUNISHMENT IS ABUSE (N=17).

VARIABLE: ↓	YES	NO	TOTAL
Women Realized Corporal Punishment	15 88.2%	02 11.8%	17
TOTAL	88.2%	11.8%	100%

Table 18, above shows that the majority (15) 88.2% of 17 implementers of the response interventions against GBV in Gwembe district indicated yes women have realized that corporal punishment is abuse while only (2) 11.8% of 17 implementers responded no women have not realized that when they are given any form of corporal punishment, then its abuse.

TABLE 19. SHOWING WHETHER GBV CASES HAVE DECLINED (N=17).

VARIABLE: ↓	YES	NO	TOTAL
Have GBV cases declined	13 76.5%	04 23.5%	17
TOTAL	76.5%	23.5%	100%

Table 19, above shows that the majority (13) 76.5% of 17 implementers of the response interventions against GBV in Gwembe district indicated that GBV cases have gone down, while (4) 23.5% of 17 implementers responded that GBV cases have not reduced at all.

4.4. Summary of Chapter

This chapter is about the findings of the study whose main objective was to assess the effectiveness of the response to Gender based violence interventions against women and girls in Gwembe district. Findings show that most of the survivors live within the radius of 5 km, and that realization about any form of violence directed at women by their spouses as abuse is high.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Overview

This discussion focuses on assessing the effectiveness of the response to Gender based violence interventions against women and girls in Gwembe district. The study appreciated demographic characteristics of survivors/ women that had experienced GBV in Gwembe district. Demographic characteristics that were relevant to this study included; age, level of education, and the economic characteristic, relevant to this study was level of family income.

Furthermore, the study sought to establish the influence of limited meaningful stakeholder engagement in design and implementation of programs, as well as constrained capacity for response and the influence of geographical factors on sexual and gender based violence response in Gwembe district.

Geographical factors which were relevant to this study, included; distance to be covered by survivors to VSU, transport availability to reach certain areas and the state of road network.

Stakeholder engagement factors relevant for this study were: limited meaningful stakeholder engagement in program design, implementation and/or funding, designing/ implementing

programs that do not address the root cause of the problem and inadequate or lack of involvement of key local implementing partners/stakeholders in the response interventions against GBV.

5. 2. Demographic Factors

5.2.1 Level of Education

The assumption underlying the level of education in assessing the impact of the response interventions against GBV in Gwembe district is that education makes one enlightened of the dangers associated GBV and would thus make one avoid provocative tendencies and would easily find amicable ways of tackling provocation from their perpetrators of GBV. Furthermore, education among survivors of GBV would facilitate prompt decision making in reporting all cases of GBV to VSU and accessing response interventions against GBV.

On this variable, the findings revealed that the majority of women (33) 48% of 69 women who ever had survived GBV in Gwembe district had tertially level of education, while (26) 38% women who ever had survived GBV in Gwembe district had primary level of education and only (10) 15% women that ever had survived GBV in Gwembe district had never been to school. These findings imply that women who had attained at least tertially education had higher percentages of surviving GBV in Gwembe district as compared to the women who had never been to school. This would also mean that women that had tertially education easily acknowledged forms of GBV and reported them.

5.3 How Economic Factors may Influence GBV

The other demographic characteristic of this study was to appreciate the economic status of households' for GBV survivors.

5.3.1 Family's economic status

For income status, the assumption was that most of women who survived or experienced GBV in Gwembe district belong to families of low income. For this study, low income families were categorized as those earning less than K250 and the moderately low income earners earned between K250-K1,000 a month while high income earners earned K1,000 and above.

From the field data it was found that he frequency table 4, indicated that the majority (46) 45.1% of 102 GBV survivors earned K250.00 or less, and (31) 30.4% of 102 survivors earned >K1, 000.00 while survivors who earned between k250.00 - k1, 000.00 were (25) 24.5%.

The findings imply that; GBV cases were more among women with low income levels as compared to those who earned higher, essentially, since the women lack money costs associated with accessing response interventions and GBV services become unaffordable to them which have perpetuating effects of the vice. Few survivors (31) 30.4% of 102 survivors earning >K1, 000.00 rhymes with high percentage survivors who attained tertially level of education as these most of women might be in formal employment or business.

The cross tabulation 2 above, indicates that for GBV survivors earning K250.00 or less as their monthly income level (19) 59% of the 32 had only primary level of education, while (9) 28% had tertially education and only (4) 13% of 32 GBV survivors never had been to school.

In addition, for GBV survivors earning K1, 000.00 and above as their monthly income level (18) 75% of the 24 tertially level of education, while those with only primary level of education were (3) 12.5% of 24 same as the GBV survivors that had never been to school were (3) 12.5%.

As for GBV survivors earning between K250.00 to K1, 000.00 as their monthly income level (6) 46.2% of the 13 had tertially level of education, however, those with only primary level of education were (4) 31% of 13, while the GBV survivors that had never been to school were (3) 23.1%.

5.4. How distance to be covered by survivors to VSU impacted GBV response

The first objective of this study was to determine whether Geographical factors impacted gender based violence in Gwembe district. The hypothesis for the Geographical factors variable was that; Distance that a GBV survivor/ victim has to cover to reach VSU, Unavailability of transport to reach certain communities, and the Condition of road network had an impact on gender based violence in Gwembe district.

Data from field indicates that the majority of women (72) 70.6% of 102 women who survived GBV lived within 5km radius, and survivors that lived beyond 15 km accounted for (22) 21.6 %, but survivors that lived between the 5-15 km were (8) 7.8% (Table 5 above)

From the data above, it may be assumed that, many survivors stay within 5km radius as compared to the survivors living beyond 5km from the VSU for accessing response interventions, this confirms the assumption that distance impacts the GBV response interventions, because the survivors that stay far especially where faster mode of transport is unavailable, would be hindered from reporting GBV cases and later on desire to seek response interventions. This is further emphasized by findings as depicted in table 4 above on distance vs most preferred mode of transport in which the majority of women (70) 97.2% of 72 women who lived within 5km radius used motor vehicle as the most convenient mode of transport and only (1) one woman used a bicycle and another one used motorbike as the most convenient mode of transport. While women that live between the radiuses of 5-15 km, (8) 100% of 8 women used motor vehicle as the most convenient mode of transport but none used bicycle or motor bike. For women that live beyond the 15 km radius, (11) 50% of 22 women used Bicycle as the most convenient mode of transport and (10) 45% women that that lived beyond 15km radius used motor vehicle as the most convenient mode of transport, but only (1) 5% used motor bike as the most convenient mode of transport.

5.4.1 How state of the road network impacted the access of GBV response interventions

From the data in table 4 above, it is assumed that the roads on the plateau area (within the 5km-15km) radius are easily passable by vehicles, thus being the most convenient mode of transport for accessing GBV response interventions in Gwembe district, as compared to the valley area (>15km radius) where only SUV or high profile motor vehicles can safely move, as such survivors that wished to report GBV cases/access response intervention services opted to bicycle mode of transport, which is already uncomfortable for a GBV survivor.

Data from the field (table 6) shows that the majority (72) 70.59% of 102 women who experienced or survived GBV in Gwembe district indicated that the state of their road network does not hinder smooth travel with regards to accessing response interventions against GBV, while (30) 29.41% of 102 GBV survivors indicated that the state of their road network hindered smooth travel with regards to accessing response interventions against GBV.

From the data in table 4 above, it is assumed that the state of road network for (30) 29.41% of 102 GBV survivors impacted the GBV response interventions, because not every survivor would afford

to endure the poor road conditions to easily report and access GBV response interventions. Thus poor road network in most of the valley areas of Gwembe district impacted the response interventions negatively.

5.3 How Stakeholder Engagement Factors Impacted GBV Response Interventions

The second objective of this study was to determine whether: limited meaningful stakeholder engagement in design and implementation of programs, Inadequate or lack of involvement of key local implementing partners or stakeholders in the implementation of response intervention programs and Designing/implementing programs that do not address the root cause impacted gender based violence in Gwembe district. The hypothesis for the stakeholder engagement variables was that limited meaningful stakeholder engagement in design and implementation of programs, Inadequate or lack of involvement of key local implementing partners or stakeholders in the implementation of response intervention programs and Designing/implementing programs that do not address the root had a negative impact on gender based violence in Gwembe district.

5.2.1 Relevance of GBV response interventions in Gwembe District

Field data (Table 7) above shows that (51) 50% of the 102 women who survived or experienced GBV in Gwembe district indicated that the response interventions against GBV were very relevant, (5) 4.9% of 102 respondents categorized the response interventions as relevant, yet (8) 7.8% of 102 respondents indicated that maybe GBV response interventions are relevant. While (9) 8.8% of the 102 women who survived or experienced GBV in Gwembe district indicated that they do not know, however, (29) 28.4% of 102 women who survived or experienced GBV in Gwembe district disclosed that the response interventions against GBV in Gwembe district were irrelevant.

The data imply that half of the survivors (51) 50% of the 102 indicated that the response interventions against GBV in Gwembe district were very relevant, as compared to those that indicated maybe (8) 7.8% of 102 and I do not know (9) 8.8% of the 102 while (29) 28.4% rated the GBV response interventions as irrelevant! The difference between very relevant and irrelevant is about 20% which means that a significant number of survivors (29) 28.4% have no confidence in GBV response interventions in Gwembe district, as the cases of GBV still persist.

Table 17, above shows that the majority (8) 47% of 17 implementers rated Relevance of response interventions against GBV in Gwembe district as being very relevant, and (6) 35.3% of 17 implementers rated the Relevance of response interventions as relevant, while only 1 implementer rated Relevance of response interventions against GBV in Gwembe district as maybe, I do not know or irrelevant respectively.

The above self-appraisal on response interventions by GBV response implementers in Gwembe district indicates that the majority 8 plus 6 (14) 82.4% of 17 see their interventions as relevant to very relevant. However, when compared against the rating by survivors 51 plus 5 (56) 54.9% of 102 survivors, it shows that the implementers' self-appraisal is not as accurate or shows some bias.

5.2.2 Availability of sensitization meetings on Response interventions in Gwembe district

Field data in (Table 9) above shows that that the majority (34) 58% of the 59 women who had ever heard of GBV programs in Gwembe district, attended at least any sensitization meeting on GBV in Gwembe district, but (13) 31% of 42 GBV survivors in Gwembe district that attended any of the meetings aimed at preventing GBV had never heard of programs aimed at preventing GBV in Gwembe district. While (29) 69% of 42 women who had never attended any GBV meeting in Gwembe district neither had ever heard of programs aimed at preventing GBV in Gwembe district.

The assumption from the variable on designing/implementation of programs that do not address the root cause is that their impact of such programs is less if not minimal. The majority of survivors (29) 69% of 42 that never attended any sensitization meeting on GBV had never heard of GBV intervention programs, which can be said to have greatly impacted the response interventions negatively, as the rate of dissemination of positive practices against GBV was less.

5.2.3 Information about GBV Response intervention program implementers in Gwembe

Data from the field (Table 8) above illustrates that the majority (99) 97.1% of 102 women who experienced or survived GBV in Gwembe district attributed the response interventions to any other implementers while YWCA, UNFRPA and World Vision all had only (1) 1% of 102 GBV survivors attributing the response interventions to these institutions.

The study assumed that impactful interventions leave long lasting impression on the intended beneficiaries of the response interventions; it was worrying to realize that the institutions behind the many programs in the district can hardly be remembered by the survivor's e.g UNFPA and YWCA. However, on further probing of the any other key players the following names were prominent; Gender desk manned by Mrs. Chiimba, Mrs. Alisheke and VSU. It was later understood that the mentioned individuals had been engaged by the respective organizations to run anti-GBV campaigns in the district as protection monitors through a subcontracted organization YWCA by UNFPA in the district, hence the survivors ended up identifying the mentioned individuals as the sole implementers of GBV interventions.

5.4 How Constrained Capacity for Response Factors Impacted GBV

The third objective of the study which mainly applies to GBV response implementers (government departments, non-governmental organizations, traditional leadership) seeks to examine whether constrained capacity for response factors impacted GBV response: Inadequate funding to VSU, Inadequate coordination among key government departments in responding to GBV, Lack of GBV one stop facility impacted gender based violence in Gwembe district. The hypothesis for the constrained capacity for response factors impacted GBV response factors variable was that; Inadequate funding to VSU, Inadequate coordination among key government departments in responding to GBV, Lack of GBV one stop facility impacted Gender Based Violence in Gwembe district. The results are tabulated below:

5.4.1 How level of funding impacted response interventions toward GBV in Gwembe

For level of funding towards GBV response interventions, it was assumed that the amount of funding towards such programs can impact the response interventions either positively or negatively. Table 13 above shows that none 0% of 17 implementers indicated that they had received adequate funding towards GBV response. While the majority (11) 64.7% of implementers indicated that they received no funding at all for response towards GBV interventions. And (6) 40% of 17 implementers disclosed that they received below average funding towards GBV interventions.

From the above picture, it shows that the amount of funding towards such an important undertaking is negligible, hence the negative indicators on certain variables, as it was already highlighted that about 30% of survivors see the response interventions to be irrelevant.

5.4.2 How collaboration impacted GBV response interventions in Gwembe district

Field data (Table 14) above shows that (12) 70.6% of 17 implementers indicated that they had been consulted or engaged in response interventions towards GBV response in Gwembe district, of the 12 that were consulted, (9) implementers indicated that the collaboration was at the level of program implementation, (3) 25% of the 12 implementers stated that they were consulted at the level of program design, while 5 implementers indicated that they were not consulted at all.

The assumption on collaboration was that limited collaboration generally leads to poor performance. This variable expects implementers to collaborate at the level program design, implementation and funding or resource mobilization. Results show that collaboration among implementers was fairly around 70.6% (12) of 17 however, it was just in the area of program implementation, neglecting the aspect of program design or planning. Hence this kind of collaboration leaves gaps.

5.4.3 Rate of collaboration in response interventions against GBV in Gwembe district

Further, Table 16, above shows that the majority (9) 53% of 17 implementers rated collaboration activities towards GBV response in Gwembe district as being very good, and (3) 18% of 17 implementers rated the collaboration as good, while (5) 29% of 17 implementers rated the collaboration activities towards GBV response in Gwembe district as below average.

It was assumed that poor collaboration among implementers had a huge impact on response interventions negatively, and field data shows that collaboration is generally fair although a gap of close to 30% in terms of key program implementers of the GBV response interventions is quiet significant.

5.4.4 How lack of GBV one stop centre in Gwembe district impacted the response interventions against GBV.

The assumption about availability of GBV one stop centre is that, when available GBV survivors can opt to move out of the abuser's home, to a safer place where they would receive holistic care and support ranging from medical, socio-economic and legal advice. In its absence, survivors are usually left with no option, but endure the abuse at the hands of the perpetrators, which has resulted in suffering deformities and death.

Gwembe district like many other districts being known for high GBV cases, coupled with poor road network in most far flung areas within the district, the lack of a GBV one stop center has impacted the response against GBV negatively as it has forced some survivors endure the negative vice because of having no such facility.

5.4.5 Referral of GBV survivors from VSU to Hospital for police report/medical care

Table 12 above illustrates that (10) 100% of 10 GBV survivors that visited VSU and were referred to hospital for medical report/check-up, all the 10 reported that effort was made to bring the perpetrator to book. While of the 92 survivors that were not referred by VSU to hospital for medical report/check-up, (6) 6.5% indicated that efforts were made to bring perpetrator to book.

It was assumed that failure by VSU to request medical authorities to examine GBV survivors, would lead to loss of necessary evidence that might be needed to prosecute perpetrators, thus all survivors need to be examined by competent medical officers as indicated, further VSU is expected to link survivors to GBV one stop center under ministry of community development and social welfare for humanitarian response and safety. Any break in this linkage ultimately leads to inadequate intervention.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study was assessing the impact of the response interventions towards GBV in Gwembe district. It determined the impact of limited meaningful stakeholder engagement in the design and implementation of response intervention programs, constrained capacity for response and geographical factors, further, the study appreciated the demographic characteristics of the GBV survivors in Gwembe district. All variables had an impact on the response interventions against GBV and the outcomes of the interventions are as follows; women realization of corporal punishment as being abuse stood at 89.9%, while whether GBV cases had declined in Gwembe district declined was 76.5%. However, reporting of cases of abuse to VSU stood at only 9.8%.

With regard to impact of the response interventions against GBV in Gwembe district, efforts to bring the perpetrators to book by VSU was (10) 100% of 10 survivors, however the (92) 90.2% of 102 survivors did not report their abuse to VSU but handled the abuse domestically, usually by survivors' relatives who charged the perpetrator with an animal e.g cow or some goats. However, all the proceeds would be taken to benefit the survivors' relatives. Information about key organizations funding and running response interventions, each of them accounted for only (1) 1 % of 102 as compared to 'others' implementer accounting for 97%, which lessens their impact on the ground as the force behind the agenda of eliminating GBV in the district. Additionally, findings

show that 90.2 % of women realized that corporal punishment is a form of abuse, GBV cases have gone down 76.5%, rate of collaboration 70.6%, level of coordination-implementation 71%, designing 25%, funding 25%, level of funding-adequate 0%, below average 40% and none at all 60%, survivors sensitized in GBV interventions 59%, Relevance of GBV response interventions Very relevant 50%, state of road network that hinders safe travel 29.4%, presence of GBV one stop center 0%,

Therefore, based on the findings, it can be concluded that, all variables i.e., geographic, limited meaningful stakeholder engagement in design/implementation of response intervention programs, constrained capacity for response and geographical factors all had an impact on the response interventions against GBV in Gwembe district. The big question that lingers on is why only (10) 9.8% of 102 survivors reported their abuse to VSU?

6.2 Recommendations

6.2.1 Recommendations for Further Research

Based on the findings from the study, i.e. only (10) 9.8% of 102 survivors reported their abuse to VSU? The following recommendations are made:

Further research needs to be done to identify the perceived benefits of using or calling family elders to sit couples down whenever there are misunderstandings that culminate in gender based violence, regardless of the extent of injury sustained by the survivor in comparison to the unwanted effects (disadvantages) of not reporting cases of GBV to VSU.

Secondly, the study only looked at the perspectives of survivors and implementers in the response interventions which do not give a full picture of the situation on the ground. There is need to triangulate the findings by looking at a larger source of information by getting the perspectives of men and perpetrators who are equally important stakeholders, on the impact of response interventions to GBV in Gwembe district.

6.2.2 Recommendations to Government and Coorporating Partners

The government, working with its cooperating partners like; UNFPA, YWCA among others to establish a response center within the Gwembe valley that will be supported with logistics to

quickly respond to cases of abuse in all sites and link the survivors to response interventions by key providers, while facilitating for prosecution of habitual perpetrators.

6.2.3 Recommendations to the District

i. The Gwembe district administration office through the victim support unit should ensure that the GBV one stop center is constructed in the district and that the road network is improved so that difficult to reach areas such as Henga, Gulumunyanga, Ntanga and Simwami to enable survivors have easy access to response intervention services and facilities.
ii. The local leadership (Chiefs and their headmen/headwomen) to always be engaged in order to discourage cultural beliefs that still accept corporal punishment against women as means of correcting erring women by her their husbands and no one should be victimized for reporting their abusers to VSU.

6.2.4 Recommendations to Program Implementers

The following recommendations for program implementers are made to decrease prevalence of GBV

i. Intensify raising awareness in the community about the risk factors for GBV and the associated dangers either through mass media, community mobilization and hand out.
ii. Improve level of collaboration among key players at all levels i.e. designing, implementation and resource mobilization.
iii. VSU to empower neighborhood watch groups with simple policing tools such as handcuffs and short button to aid in immobilizing perpetrators while awaiting professional police intervention.

6.3 Implication for Public Health

The implication of this study for public health is that, gender based violence will continue being a challenge to nursing as long as women's education and economic collaboration among key players does not involve all the three cardinal levels (program design, implementation and resource mobilization then GBV will still be an issue, and as long as one stop centre is not established, response interventions will not be holistic, as long as the road network is not made better for easy

passage, then GBV survivors who live in far flung areas like Henga, Gulumunyanga, and Ntanga will have no easy access to reporting cases as well later on access response interventions. As long as the level of funding to key institutions like VSU, MCDSS, Health, MOGE, ZANIS and local implementing groups such as Neighborhood watch.

6.3.1 Public Health Education

Public health education should incorporate key messages on how to get women get involved in**,** their own health matters. Public health students should be enlightened about the importance of Intersectoral approach in promoting the safe and welfare of women in the society. Public health education should empower students to positively influence their clients to make sound decisions through IEC, advocacy and counseling.

6.3.2 Public Health Practice

Sexual and Gender based violence is really a public health practice challenge. Concerted effort must be incorporated in order to give no room to the commonly associated characteristics influencing gender based violence, and factors hindering the effective response interventions, otherwise the fight for gender inclusivity in public health practice, as well the quest to meet SDG number 5 will grapple, as long as the phenomenon continues.

6.3.3. Public Health Administration

Public health administrators have an intercessory role to play as far as sexual and gender based violence is concerned, since the factors associated are cross cutting, ranging from geographic, constrained capacity for response factors and limited stakeholder engagement/involvement factors. This requires Public health administrators to lobby with their administrative counter-parts in other sectors and influencing policy makers and legislators to put in place legislation that favor gender inclusivity and peaceful co-existence family members and society as a whole.

6.3.4 Public Health Research

Public health research still remains fundamental to public health practice. Since public health is a science like any other, the practice needs research for its running. More evidence based result yielding interventions are required in order to safe guard women and girls' welfare and gender

inclusiveness. More research needs to be done in order to consolidate public health practice interventions in the quest to further reduce prevalence of GBV.

6.4 Limitations of the study

The study was conducted in few settings due to limited time and resources.
The sample of respondents under key government implementers is less by one (1) as one of the key respondents did not respond to the questionnaire despite several appeals made.

6.5 Conflict of Interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

REFERENCE

1. Alys M. Willman and Crystal Corman (2013). Gender-Based violence, what is the world bank doing- a systematic review)
2. Cerf.un.org>19-PR-ZMB-39661
3. Conclusions of 57th Session of Commission on the Status of Women (CSW) with strong focus on prevention. –http://www.unwomen.org/en/what-we-do/ending-violence-against women/prevention#sthash.62myijyb.dpuf
4. (EU 2017) Action Document for Sexual and Gender-Based Violence (SGBV) Prevention and Support to SGBV Survivors in Zambia, the programme complements and builds on recognized gaps and best practices from other (SGBV) programmes
5. George Zimbiri et. Al (2017). "GRZ/UN Joint programme on gender-based violence".
6. Jill Keesburry et. Al (2012) "A review and evaluation of multi-sectoral response services ("one-stop centres") for gender-based violence in Kenya and Zambia"
7. Keesbury J and Askew I, (2010). "Comprehensive responses to gender-based violence in low-resource settings: Lessons learned from implementation". Population Council. Lusaka, Zambia.
8. Honduras Safer Municipalities (P130819)
9. Ministry of home affairs, Victim support unit statistics. Retrieved on 5th March, 2021.
10. Population Council, (2008). "Sexual and gender-based violence in Africa: Key issues for programming". Population Council: Nairobi, Kenya.
11. TAWLA, (2014) "Review of Laws and Policies related to gender-based violence of Tanzania mainland"

12. Terry, Geraldine (2007) “Women’s Rights. Oxfam. Small Guides to Big Issues”.
13. USAID- DFID Stop GBV programme, Joint UN GBV programme, and various CSO projects.

APPENDICES

Appendix i:

RESEARCH SCHEDULE

TASK TO BE PERFORMED	TIME FRAME		RESPONSIBLE PERSON
	DATES	DURATION	
Literature review	October To December 2021	3 month	Investigator
Development and finalization of the research proposal	January To May 2022	5 months	Investigator
Seeking ethical clearance	June To July 2022	1 month	Investigator
Data collection (main study)	15th To 26th August To	10 days	Investigator
Data analysis	1st To 22nd September, 2022	21 days	Investigator
Report writing	26/09 To 27/10/2022	30 days	Investigator
Defending research results	21St April, 2023	10 Minutes	Investigator
Publishing Dissertation	May, 2023	3 days	Investigator

Appendix 2: **RESEARCH BUDGET**

No.	ITEM	UNIT COST(ZMK)	QUANTITY	TOTAL (ZMK)	
1.	**FIELD WORK LODGING/TRAVEL EXPENSES** • Lodging & accommodation For 2 people • Meals for 2 people/day • Hiring of motor bike plus fuel • Charges for the Biker	 K350.00 X 2 (K700) K90/day X 2 (180) K250 K250	 10 days 10 days 10 days 10 days	 K7,000.00 K1.800.00 K2,500 K2500	
	SUBTOTAL			**K16,300.00**	**K13,300**
2.	**SECRETARIAL SERVICES** • Ball pens • Tipex • Clear Bags • Note books • Flash disk (USB) • Stapler • Staples • Scientific calculator	 3.00 20.00 20.00 1.00 100.00 35.00 15.00 80.00	 10 2 Packet 1 1 1 1 1 Box 1	 30.00 40.00 20.00 25.00 100.00 35.00 15.00 80	

	• Perforator • Spiral binding • Printing	40.00 30.00 1080 pages	1 4 @ K4/Page	40.00 120.00 4320.00	
SUBTOTAL				**K4,845**	
CONTINGENCY FUND				**K2,114.5**	**K4,845** **K2,114.5**
GRAND TOTAL					**K20,759.5**

Appendix iii: **CONSENT FORM**

My name is Morris Debson Malambo and I am a student pursuing a Master of Science degree in Public health at The University of Zambia. I am conducting a study on assessing the effectiveness of the response to sexual and gender Based Violence (GBV) intervention in Gwembe District. Your input will help me assess the effectiveness of the response to sexual and gender Based Violence (GBV) intervention in Gwembe District

Participation is voluntary: that is, you may decide to participate or not. If you agree to participate then you will answer a few questions that I will ask you, and this will last for about 15 minutes.

Any information you give will highly be kept confidential and used only for the study. For verification about this study you may contact:

The University of Zambia, Institute of Distance Education School of Public Health.

If you agree to participate in the study, please sign / thumbprint

Signature/thumbprint of respondent……. Date…….

Signature of investigator……Date…….

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that:

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in is purely voluntary.

I …….

(Names)

Agree to take part in this study.

Signed …… Date: ……..

(Participant)

Participant's signature or thumb print

Signed: …….. Date: …….(Witness)

Signed: …….. Date: …… (Researcher)

Appendix 1:

QUESTIONNAIRE FOR SGBV SURVIVORS

THE UNIVERSITY OF ZAMBIA

SCHOOL OF PUBLIC HEALTH

Research Questionnaire

Dear Respondent,

I am a student pursuing a Master of Science degree in Public health at The University of Zambia. I am conducting a study on assessing the effectiveness of the response to Gender Based Violence (GBV) intervention in Gwembe District. You have been randomly selected to help in providing information on this survey and that any information provided in this questionnaire will be strictly treated as confidential.

The success of this survey depends on your co-operation and the correctness of the information you provide in the spaces provided. I therefore, kindly request you to fill in this questionnaire.

Thanking you in advance for your anticipated co-operation.

RESEARCHER: MALAMBO MORRIS DEBSON.

……

INSTRUCTIONS

*** Do not write your name or any identification mark on this questionnaire. Please tick or write your response as the question demands.**

SECTION A: DEMOGRAPHIC DATA

1. How old were you on your last birthday? ……

2. Where do you live (Village) who is your Headman……?
3. How far do you live from the victim Support Unit of the Zambian police or neighborhood?
   (a) Less than 5km ☐
   (b) Between 5 and 15km ☐
   (c) Over 15 km ☐

4. Does the state of your road network hinder smooth travel by the most reliable form of transport to and fro institutions that are involved in the response interventions against GBV?

   Yes ☐ No ☐

5. Do you think staying far from the victim support unit or neighborhood watch can prevent someone from reporting sexual or gender based violence to law enforcers? a) Yes ☐ b)No ☐
6. What is most convenient mode of transport that is used into and out of from community?
   a. Motor vehicle ☐
   b. Motor Bike ☐
   c. Oxcart ☐
   d. Bicycle ☐
7. What is your marital status?

   a. Single ☐ b. Married ☐ c. Divorced ☐

8. What is your monthly income?

   (a) <K250 ☐ b. K250-K1000 ☐ c. > K1000 ☐
9. What is your highest level of education?
   (a) Never been to school ☐
   (b) Primary ☐
   (c) Secondary or higher ☐

SECTION B: DETERMINING WOMEN'S ACKNOWLEDMENT OF GBV AGAINST

10. Have you ever survived any form of GBV at the in this district? a. Yes ☐ b. No ☐

SECTION C: DETERMINING THE LEVEL OF INVOLVEMENT OF KEY STAKEHOLDER IN GBV PROGRAM DESIGN AND IMPLEMENTATION

11. Have you ever heard about programs aimed at preventing GBV cases in the district?
   (a) Yes ☐
   (b) No ☐

12. Name the organization(s) that you know have run or are presently running programs fighting SGBV in the district? Tick any from the list below?
    a. UNFPA
    b. YWCA
    c. WORLD VISION
    d. HEIFER
    e. SAVE THE CHILDREN
    f. Any other……..
13. Name the organization that is more renown against the GBV fight in this district……...
14. Have you ever attended any of their GBV program awareness meetings?
    (a) Yes ☐
    (b) No ☐
15. If yes can you point out any key points raised in such meetings that you remember.....
16. Have you ever been involved or consulted by any organization fighting GBV issues in the district on any of the following stages?
    (a) Program designing Yes ☐ No. ☐
    (b) Program Implementation Yes ☐ No. ☐

17. In your own view how do you rate the relevance of the intervention or programs aimed at preventing GBV cases in Gwembe District
    (a) Very Relevant ☐
    (b) Relevant ☐
    (c) May be ☐
    (d) I do not know ☐
    (e) Irrelevant ☐

18. In your own understanding how can you describe the results or outcomes of the combined intervention against GBV in the district?
    (a) GBV cases in the community have declined; Yes ☐ No ☐
    (b) Women have realized that corporal punishment is abuse. Yes ☐ No ☐
    (c) The respective organizations are engaging or consulting key local stakeholders in designing or implementing programs in fighting against GBV Yes ☐ No ☐
19. Finally, how do you describe the multi-sectoral response to GBV cases i.e. (the VSU, Health and community development) plus supporting organizations
    a) Were you intimidated or criticized by VSU officers? Yes ☐ No ☐

b) Were efforts to bring the perpetrator to book made by VSU? Yes ☐ No ☐

c) Did VSU refer you to community & social welfare any services? Yes ☐ No ☐

d) Were you referred to any health facility/Hospital for check-up/care Yes ☐ No ☐

e) Roughly how much money did the entire process cost you? .....

20. What can be done best by the program interested organization to win the fight against GBV in Gwembe district? .....

END OF INTERVIEW! THANK YOU FOR YOUR PARTIPATION!

Appendix 2:

KII GUIDE FOR PROGRAM DESIGNERS & IMPLEMENTORS

THE UNIVERSITY OF ZAMBIA

SCHOOL OF PUBLIC HEALTH

Research Questionnaire

Dear Respondent,

I am a student pursuing a Master of Science degree in Public health at The University of Zambia. I am conducting a study on assessing the effectiveness of the response to Gender Based Violence (GBV) intervention in Gwembe District. You have been purposefully selected to help in providing information on this survey and that any information provided in this questionnaire will be strictly treated as confidential.

The success of this survey depends on your co-operation and the correctness of the information you provide in the spaces provided. I therefore, kindly request you to fill in this questionnaire.

Thanking you in advance for your anticipated co-operation.

RESEARCHER: MALAMBO MORRIS DEBSON.

Demographic Information: ……..

Name of Ministry: ……..

Position of Respondent: …….

Sex of Respondent: ……

Name of Interviewer: **……**

SECTION ONE: SCOPE OF THE PROBLEM AND HELP-SEEKING BEHAVIOUR

1. Is gender based violence a challenge in this area? Yes ☐ No ☐
2. What are the situations that pre-dispose people to Gender based violence (GBV) in this state?
   a. Poverty ☐
   b. Culture ☐
   c. social status ☐
   d. Any other ☐
3. What do people in this s do to protect themselves from gender-based violence?

   ……

   ……

   ……
4. What does the government do to protect people from the risk of GBV?

   Specific interventions…….

   ……..

   Activities and programs:……..

……...

8. Are there any individuals, organizations or services in this district that conducts GBV prevention? Please list them:

   a. ……. e. ……..
   b. ……. f. ……..
   c. ……. g. ……..
   d. ……. h. ……

9. What are the gaps in the GBV services provided in the district?.....

……

……

10. Has the problem of GBV in this district **gotten worse**, **better**, or **stayed the same** in the last year?

- Better ☐
- Stayed the same ☐
- Gotten worse ☐

If there has been a change, what has caused it?.....

……

……

11. What barriers do women and girls or men and boys face in reporting GBV in this community? Is it:

- Stigma against survivors, ☐
- Acceptance of violence as normal, ☐
- Logistical (cost, distance, hours of operation, etc.), ☐
- Lack of awareness of services, ☐
- Lack of trust in the benefits of services, ☐
- Lack of coordination between services, ☐
- Lack of follow up, or ☐
- Lack of the quality of services). ☐

SECTION TWO: GBV PREVALENCE DATA

1. What is your ministry's focus in preventing or responding to GBV?.....

   ……

   ……

   ……

2. What particular needs of GBV survivors does your ministry focus on?.....

   ……

   ……

3. What is the average number of GBV cases that was reported within the past one year?.....

4. What are the age ranges of survivors that your ministry target interventions for?.....

SECTION THREE: POLICIES, PROTOCOLS

1. What policies exist at the national and in this state in relation to GBV prevention and response?.....

.....

.....

2. To what extent are these policies implemented?.....

……

……..

3. Are you aware of existing policy/protocol specifically to your ministry or department for working with GBV survivors? ……...…….....

……

……

4. Does your ministry or department use any guidelines on GBV Yes ☐ No ☐
5. (If yes, tick whether WHO ☐, National ☐ or district adapted guideline ☐)?

SECTION FOUR: INFRASTRUCTURE/SERVICE DELIVERY

1. At the district level, what is the government doing in relation to GBV prevention and response?

……..

……

……

- What types of support/services does this ministry or department provide to GBV survivors?
- Health services ☐
- supportive counseling ☐
- case management ☐
- Safety planning/homes, ☐
- legal aid, Law enforcement, ☐
- Economic/livelihoods services Other (please describe) ☐

2. Does the ministry/department make budgetary provisions for preventing and responding to GBV? Yes ☐ No ☐

If yes, in what areas are the budgets channeled?.....

……...

……

6. Does the ministry or department facilitate provision of economic empowerment or livelihood activities for survivors? Yes ☐ No
7. IF yes (please describe, for example, income generating activities,
   - vocational training, ☐
   - savings and loans clubs, ☐
   - literacy programs, ☐
   - civil society organizing/advocacy ☐
   - Any other ☐

SECTION FIVE: STAFF CAPACITY

1. Does the ministry provide/support capacity building for GBV first responders/service providers under its department/purview? Yes ☐ No ☐

   If yes, how do you do that?.....

   ……

   ……

SECTION SIX: REFERRAL and COORDINATION

1. Does the department participate in or organize local GBV coordination meetings? If yes,
   - How often? …….
   - If no, why not?.....
2. Does the department have a coordination mechanism in place to coordinate all activities of referral services/providers? Yes ☐ No ☐
   - If yes, how do you do that? …….....

     ……

     ……..
   - If no, which ministry is responsible for the coordination?)…….....

     ……
3. Has your ministry conducted a mapping of all GBV prevention and response services available in the district? Yes ☐ No ☐
4. What challenges does your Ministry/LGA have in preventing and responding to GBV?

- » Funding ☐
- » Poor logistics, ☐
- » Poor collaboration, ☐
- » Lack of expertise, ☐
- » Lack of training, ☐
- » Lack of government commitment, ☐
- » Political instability, ☐
- » Manpower shortage) ☐
- » Any other comments?.....
  ……
  ……..

CLOSE THE INTERVIEW:

Thank you for your time and ideas. This has been extremely helpful.

Appendix 3:

FGD/KII GUIDE FOR PROGRAM DESIGNERS & IMPLEMENTORS

THE UNIVERSITY OF ZAMBIA

SCHOOL OF PUBLIC HEALTH

Research Questionnaire

Dear Respondent,

I am a student pursuing a Master of Science degree in Public health at The University of Zambia. I am conducting a study on assessing the effectiveness of the response to Gender Based Violence (GBV) intervention in Gwembe District. You have been purposefully selected to help in providing information on this survey and that any information provided in this questionnaire will be strictly treated as confidential.

The success of this survey depends on your co-operation and the correctness of the information you provide in the spaces provided. I therefore, kindly request you to fill in this questionnaire.

Thanking you in advance for your anticipated co-operation.

RESEARCHER: MALAMBO MORRIS DEBSON.

INSTRUCTIONS

*** Your name or any identification mark on this questionnaire is not mandatory. Please tick or write your response as the question demands.**

1. What is the name of the institution you come from/present?…….....
   ……
2. What is your position/title? .....
3. What role does your institution play in GBV?

   a. GBV program design ☐
   b. GBV program implementer ☐
   c. GBV programs Funder ☐
   d. Government department ☐ specify your role……
      …….

4. Have you ever been involved or consulted by any other organization involved in the response intervention to GBV in Gwembe district?
   a. Yes ☐
   b. No ☐

5. At what level of GBV response intervention has your institution been engaged by other partners?

    a. Program design ☐
    b. Implementation ☐
    c. Program funder ☐

6. If yes, how do you rate the collaboration?

    a. Very good ☐
    b. Good ☐
    c. Below average ☐

7. Have you ever involved or consulted any other organization involved in the response interventions to GBV in Gwembe district?

    a. Yes ☐
    b. No ☐

8. At what level of GBV response intervention did your institution engage other stakeholders?
    d. Program design ☐
    e. Implementation ☐
    f. Program funder ☐

9. Name the organization(s) that you know have conducted or are presently running GBV response intervention programs against SGBV in the district? Tick any from the list below?
    g. UNFPA
    h. YWCA
    i. WORLD VISION
    j. HEIFER
    k. SAVE THE CHILDREN
    l. Mention any other ……

10. From the list above name the organization that is more renown in the response to GBV fight in Gwembe district……...

11. Have you ever been involved or consulted by any organization fighting GBV issues in the district on any of the following stages?

    a. Program designing Yes ☐ No. ☐
    b. Program Implementation Yes ☐ No. ☐

12. How do you perceive the relevance of the response interventions aimed at preventing GBV cases in Gwembe District?

    a. Very Relevant ☐

b. Relevant ☐
c. May be ☐
d. I do not know ☐
e. Irrelevant ☐

13. In your own understanding how can you describe the results or outcomes of the combined intervention against GBV in the district?
    a. GBV cases in the community have declined; Yes ☐ No ☐
    b. Women have realized that corporal punishment is abuse. Yes ☐ No ☐
    c. The respective organizations are engaging or consulting key local stakeholders in designing and implementing programs in fighting against GBV Yes ☐ No ☐

14. Finally, how do you describe the multi-sectoral response to GBV cases i.e. (the VSU, Health department, education department and community development & Social welfare department) plus supporting non-governmental organizations……
    …….
15. What can be best done by key organization to win the fight against GBV in Gwembe district?
    .....
    ……

16. How do you rate the level of funding you have towards the response interventions to GBV?
    a. None at all ☐
    b. Below Average ☐
    c. Adequate ☐

17. Describe the challenges that your institution faces in the GBV response intervention?
    …….
    ……
    …….

END OF INTERVIEW

THANK YOU FOR YOUR PARTIPATION!